



ACHIEVING BETTER HEALTH OUTCOMES: The Oregon Benchmark Experience

Howard M. Leichter and Jeffrey Tryens

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Foreword

The development and publication of statistical indicators of the health status and well-being of populations has been increasing in the United States and internationally. These indicators still have less influence on health policy than the publication of data about leading economic indicators has on business decisions. However, indicators of health status are attracting attention among officials at all levels of government as well as among private-sector executives making decisions about such issues as where to locate or relocate operations.

The state of Oregon in 1989 began to devise indicators of well-being, calling them benchmarks, as part of a long-term project to improve the economy of the state initiated by then-governor Neil Goldschmidt. The Oregon Progress Board (OPB), a public body whose members are leaders of the community, business, and government, manages the benchmarking process.

This report examines and assesses the history of benchmarking for health by the OPB. Its authors are well qualified for their task. Jeffrey Tryens has been executive director of the OPB since 1995. Howard Leichter, professor of political science at Linfield College, McMinnville, Oregon, has published books and articles about policy for health care and public health.

Leichter and Tryens emphasize changes in the mission and activities of the OPB that began in 1996, when Governor John Kitzhaber convened a task force to reassess the economic development project begun seven years earlier. This reassessment resulted in the reauthorization of the Board in 1997 and to an expansion of its responsibilities in 2001.

The authors describe both successes and failures of benchmarking in Oregon. Perhaps most important, they demonstrate that although benchmarking (or any other use of indicators) can bring health problems into better focus, it cannot cause problems to be solved. Indicators are tools that can be used to inform policy; they are not substitutes for the politics of policymaking.

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Daniel M. Fox
President

Samuel L. Milbank
Chairman

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Brian Atchinson, Executive Director, Insurance Marketplace Standards Association, Washington, D.C.; Lenny Bjorenson, Department of Human Services, Salem; Deborah Bohr, Vice President, Health Research and Educational Trust, Chicago, Ill.; Jo Ivey Boufford, Dean, Robert F. Wagner Graduate School of Public Service, New York University, New York; Neil Bryant, State Senator, Bend; Sue Cameron, Executive Director, Livable Oregon, Portland; Robert J. Carl, Jr., Director, Rhode Island Department of Administration, Providence, R.I.; Doug Carlson, Commission on Children and Families, McMinnville; John D. Chapin, Administrator, Division of Public Health, Wisconsin Department of Health and Family Services, Madison, Wisc.; Olivia Clark, Legislative and Intergovernment Relations Director, Office of the Governor, Salem; Brenda Comini, Crook County Commission on Children and Families, Prineville; Jean Cowan, Commissioner, Lincoln County, Newport; Hersh Crawford, Director, Office of Medical Assistance Programs, Oregon Department of Human Services, Salem; Pam Curtis, Policy Analyst, Office of the Governor, Salem; Jeff Davis, Administrator, Marion County Health Department, Salem; Philip Davies, Senior Health Economist, World Health Organization, Geneva, Switzerland; Patricia Day, Senior Research Officer, School of Humanities and Social Sciences, University of Bath, U.K.; Gwen Dayton, Vice President and General Counsel, Oregon Association of Hospital & Health Systems, Lake Oswego; Sue Densmore, Communications Strategies, Medford; Joella Dethman, Hood River County Commission on Children and Families, Hood River; Chuck Diamond, Oregon Department of Human Services, Salem; Alan Ehrenhalt, Executive Editor, *Governing*, Washington, D.C.; Tom Engle, Clatsop County Health Department, Astoria; Ramona Foley, Director, State Office for Services to Children & Families, Salem; Karmen Fore, Commission on Children and Families, Salem; Randy Franke, Commissioner, Marion County, Salem; Michael Garland, Associate Director, Center for Ethics in Health Care, Oregon Health and Science University, Portland; Mark Gibson, Policy Advisor for Health Care, Human Services & Labor, Office of the Governor, Salem; Lee Greenfield, Principal Administrative Assistant, Hennepin County Health and Human Services Policy Center, Minneapolis, Minn.; James K. Haveman, Director, Michigan Department of Community Health, Lansing, Mich.; Grant Higginson, State Health Officer and Deputy Administrator, Health Division, Oregon Department of Human Services, Salem; Jono Hilder, West Linn; Mona K. Hinds, Today's Choices Tomorrow's Community, Salem; Tonia Hunt, Public Policy Director, Children First for Oregon, Portland; Susan Irwin, Director, Washington County Department of Health, Hillsboro; Chris Johnson, Yamhill County Public Health Division, McMinnville; Jan Kaplan, Lincoln County Health Department, Newport; Nancy J. Kaufman, Vice President, The Robert Wood Johnson Foundation, Princeton, N.J.; Jan Kenna, Columbia County Commission on Children and Families, St. Helens; Robert Landauer, *The Oregonian*, Portland; Mickey Lansing, Commission on Children and Families, Salem; Leslie Lewis, Commissioner, Yamhill County Board of Commissioners, McMinnville; David Litts, Special Assistant to the Assistant Secretary for Health, U.S. Department of Health and Human Services, Washington, D.C.; James Lussier, President, St. Charles Hospital, Bend; Deidre Molander, Oregon Business Council, Portland; Carin Niebuhr, Director, Jackson County Commission on Children and Families, Medford; Kathleen O'Leary, Director, Clatsop County Commission on Children and Families, Astoria; Gary Oxman, Multnomah County Health Department, Portland; Clara Pratt, Professor of Health and Human Sciences Administration, Oregon State University, Corvallis; Bob Repine, Director, Oregon Department of Housing and Community Services, Salem; Rick Roger, Chief Executive Officer, Capital Health Region, Victoria, Canada; Rachelle Schaaf, Curry County Commission on Children and Families, Gold Beach; Chuck Sheketoff, Oregon Center for Public Policy, Silverton; Barney Speight, Director, Public Policy and Government Relations, Kaiser Permanente, Portland; Beverly Stein, Chair, Board of Commissioners, Multnomah County, Portland; Jerry Street, Administrator, Jefferson County Health Department, Madras; Peggi Timm, Baker City; Gary Weeks, Oregon Department of Human Services, Salem; Ruth Whitnah, Baker County Commission on Children and Families, Baker City; David Wiener, Executive Assistant to the Mayor of Lansing, Mayor's Office, Lansing, Mich.; Diane Williams, Ashland; Jennifer Woodward, State Health Division, Portland; and Duncan Wyse, President, Oregon Business Council, Portland.

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Executive Summary

Oregon's strategic planning approach to public health, using a comprehensive, statewide process and societal-level indicators of well-being, is widely recognized as an innovative, successful program. This report explores what this approach has done to improve the health of Oregonians.

What distinguishes the Oregon process from similar data-gathering in other states is its comprehensiveness. Health indicators are considered an integral part of a broad system, based on outcomes, of monitoring progress toward a desirable future. Good health is essential to a wide range of Oregon's goals, including a strong

economy and safe, caring communities.

In 1989 Governor Neil Goldschmidt developed a 20-year vision, called *Oregon Shines*, to stimulate the state's economic transformation. As Oregon struggled to emerge from a decade of recession, he believed Oregonians needed a strategic vision in order to embrace new economic realities requiring better-educated workers, greater sensitivity to the global economy, and topnotch public services. Later a set of indicators called Oregon benchmarks was developed to monitor the evolution of the vision. (Oregon's use of the word "benchmark" confuses many people. It commonly refers to the standard to which a result is compared. But in Oregon the word is used to mean an indicator of societal well-being.) The state legislature created the Oregon Progress Board, made up of community, business, and political leaders, to oversee the process.

The *Oregon Shines* benchmark system has had mixed results: Oregon fared no better than the U.S. average in improving its health between 1990 and 2000. Compared to national data, the state performed better than that average in only five of ten categories. Oregon leaders, however, generally believe the process has improved health outcomes by elevating their status in public deliberations.

The *Oregon Shines* story is divided into three overlapping periods: high hopes, disillusionment, and rebuilding. The period of high hopes was characterized by exuberant support from two successive governors, many legislators, community leaders, and the Clinton administration. Hopes rose highest when Oregon's efforts were repeatedly singled out by the Clinton administration during 1994 and 1995 as nationally important best practices.

Ironically, 1995 was the same year in which the Progress Board reached its nadir. The legislature allowed the Board's authorizing statute to expire, requiring an executive order by the governor to keep the *Oregon Shines* process alive. The Board's enthusiastic supporters saw a national model in the making. Increasingly conservative legislative leaders saw, at best, a questionable use of taxpayers' money.

Rebuilding began in 1996 when Governor John A. Kitzhaber convened a citizens' task force to reassess *Oregon Shines*. A narrower process, with a decidedly practical, rather than inspirational, focus emerged. As a result the legislature reversed itself in 1997, permanently reauthorizing the Progress Board. In 2001 it took an additional step toward making the board a permanent part of state government, moving it into the state's central administrative department and giving it responsibility for developing state agency performance guidelines.

Oregon's system faces many of the same problems of governments around the world that use performance indicators: (1) cause and effect relationships are difficult to identify; (2) good or bad performance on benchmarks is too often considered the exclusive responsibility of public agencies; (3) the reasons for benchmark changes are seldom understood or explained; and (4) the reasons for choosing benchmarks are often not well thought out.

During their 11-year history, the benchmarks that are at the core of Oregon's approach have served many purposes related to vision, budgeting, community mobilization, agency accountability, and public education. In the early 1990s, benchmarks were most valued as "magnets for collaboration" for disparate interest groups. Later political pressure built to make public agencies accountable for influencing benchmark trends. Creating meaningful links between state agencies and Oregon benchmarks remains a vexing problem for Oregon.

Since 1991 political leaders have tried to harness state agency resources to help achieve the *Oregon Shines* vision. Unrealistic targets may have hamstrung early attempts at linking performance measures to Oregon benchmarks. By 1995 budget leaders showed little interest in linking budget allocations to the benchmarks' lofty targets. After four years of rebuilding interest, state officials launched a new initiative in 2001 to create a consistent framework for agency performance measures.

Many health practitioners believe that this program has succeeded most at the county level, where public-private collaborations have helped to solve social problems. By educating counties about their trends and relative standing among their peers, the Progress Board has spurred action on a variety of health-related issues. This is especially true in instances where benchmark comparisons have drawn attention to counties that compare poorly to their peers.

Three case studies demonstrate the strengths and weaknesses of Oregon's approach. A public-private initiative on early-childhood immunization, which helped spur a major Clinton-era initiative on intergovernmental cooperation, demonstrates how complex the task of changing a benchmark trend can be, even for something simple. An equally sensitive benchmark, early prenatal care, explores the intersection of politics, policymaking, and target setting. And the facts about teen pregnancy in a rural county show that, while good outcomes can help mobilize local resources, more is needed to assure permanent health improvements.

The report briefly reviews performance-based programs in six states that most closely approximate the Oregon model: Connecticut, Florida, Maine, Minnesota, North Carolina, and Vermont. Like the Oregon model, most of these state programs include: a societal-wide, long-term vision; public participation in the formulation of both the

overall goals; the use of indicators to measure progress toward the goals; and regular publication of progress reports.

Five key recommendations emerge from the study: (1) more analysis is needed to explain why the state or individual counties have, or have not, achieved benchmark targets; (2) data below the county level are needed to help local officials home in on public health problems; (3) health benchmarks should be reexamined periodically with an eye toward their internal logic and relevance; (4) relationships between health benchmarks and other benchmarks need to be clarified; and (5) community ownership of benchmarks must be reinforced.

Introduction

In May 1989 Oregon's Governor Neil Goldschmidt unveiled *Oregon Shines*, a strategic plan that contained various economic initiatives meant to make Oregon "a uniquely wonderful place to live" with "a prosperous economy amid a rewarding quality of life." Two years later the state legislature created the Oregon Progress Board (OPB or the Board) to act as caretaker of the *Oregon Shines* vision. The Board developed indicators of progress, or benchmarks, grouped into three broad categories: "exceptional people," an "outstanding quality of life," and, a "diverse, robust economy." In 1991 the Board set specific targets for 2000 and 2010 for each benchmark. Since then it has issued biennial reports on the state's progress toward the goals.

Unlike public-sector performance systems in other states and localities, Oregon's system has not assigned responsibility for meeting specific targets to any state agency. The benchmarks and the vision they embody are theoretically the responsibility of all Oregonians.¹ Essentially an economic development plan, *Oregon Shines* was presented as a broad, deep analysis of the state's economy. For example, it stipulated that in order to modernize and revitalize the economy, the state needed a "healthy social fabric," including the physical and mental well-being of Oregonians. Thus the introduction of the benchmarks in 1990 included targets for 2000 and 2010 for infant mortality and childhood immunization rates, teen pregnancy, substance abuse by schoolchildren, and tobacco and alcohol use by adults. A decade after it first set these targets, the Board released its fifth biennial report to the state legislature on Oregon's progress toward realizing its targets for 2000.

Measuring Progress

Although the Oregon benchmark system does not merely measure progress toward numerical targets, many people will judge it in terms of that very standard. It is useful, then, to begin by addressing the inevitable question: How is Oregon doing?

The data in table 1 display the state's progress toward the health targets it set for itself in 1990. The first four columns show: (1) the health status of Oregonians in 1990; (2) their status for the latest year available; (3) the targets for 2000 set by the Progress Board in 1990; and (4) whether those targets were achieved.

Table 1 demonstrates that Oregonians attained only one of the original targets: infant mortality was reduced from 8.3 deaths per 1,000 live births to 6.0. In one case—alcohol use among eighth-grade students—the group was actually worse off than in 1990. There was significant progress in early immunization of two-year-olds (from 67 to 80 percent) and teen pregnancy rates (from 19.7 to 15.9 per 1,000 females aged 10 to 17). Nevertheless, the state fell far short of most of its original 2000 targets.

In 1996 a top-to-bottom review of the *Oregon Shines* process resulted in significant changes in the targets for 2000 and 2010. For the first time, the Board established a clear criterion for setting targets, specifying that they should be ambitious but realistic. According to the revised 2000 targets, Oregonians reached the goals in six of the 11 health measures and came very close on two others—the percentages of people without health insurance and of adults who do not smoke. The last two columns in table 1 show the results.

TABLE 1. MEASURING THE HEALTH OF OREGONIANS

How Oregon was in 1990	How Oregon was in latest year	Original target for 2000 (1990)	Original target achieved?	Revised target for 2000 (1996)	Revised target achieved?
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Benchmark	Where Ore in 1990	Where Ore in most rec reported*	Original tar 2000 (seti	Attainmen original tar	Revised tar 2000 (seti	Attainmen revised tar
Percentage of Oregonians, without health insurance ¹	16	12	0	no	9	no
Percentage of babies whose mothers had early prenatal care ²	76	81	95	no	90	no
Infant mortality per 1,000 live births ²	8.3	6.0	6.0	yes	6.0	yes
Percentage of two-year-olds adequately immunized** ³	67	80	100	no	90	no
Percentage of adults who do not smoke tobacco ⁴	78	79	85	no	81	no
Teen pregnancy rate per 1,000 aged 10 to 17 years ²	19.7	13	8	no	15	yes
Percentage of infants whose mothers did not use alcohol tobacco ²	95 78	98 86	99 95	no no	98 85	yes yes
Percentage of eighth-grade students who report using illicit drugs alcohol in the previous month ⁵	14 23	14 26	3 3	no no	15 26	yes yes
Number of children under 18 abused or neglected per 1,000 ⁶	11.3	12.2	6	no	9	no

* Data for either 1999 or 2000. ** Data for 1994.

1. Oregon Population Survey, 1990–2000, a random-sample telephone survey of Oregon households conducted in even-numbered years.
2. Oregon Department of Human Services, Oregon Health Division, Center for Health Statistics, *Oregon Vital Statistics Annual Report*, 1990 and 1999.
3. Data for 1994 from *Certificate Base Survey*, Oregon Department of Human Services, Oregon Health Division, 1994. Data for 2000 from Centers for Disease Control and Prevention, *Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State*, U.S. National Immunization Survey, 1995–2000.
4. Oregon Department of Human Services, Oregon Health Division, Center for Health Statistics, *Behavioral Risk Factor Surveillance System*, 1990 and 1999.
5. Oregon Department of Human Services, Office of Alcohol and Drug Abuse Programs, *Oregon Public School Drug Use Survey*, 1990–2000, a biennial poll of 12,000 Oregon students in the sixth, eighth, and eleventh grades.
6. Oregon Department of Human Services, Oregon State Office for Services to Children and Families, Research Unit, *Child Abuse and Neglect Report*, 1990 and 2000.

Which is the fairer assessment of Oregon's success? Critics say that changing the targets in midstream was a blatant attempt to avoid bad news. Supporters argue that the changes were an appropriate response to the experience with target setting that occurred between 1990 and 1996.

Clearly, the original targets were highly idealistic and, in hindsight, unrealistic. For example, no state had achieved a 95 percent coverage rate for early prenatal care in 1990. In fact, the only states that were achieving a 90 percent rate had extensive home visitation programs, something Oregon lacked. Nearly every target was set with equally high hopes.

To their key supporters, the original benchmarks were tools to inspire Oregonians, not to manage state government. Governor Goldschmidt's successor, Governor Barbara Roberts, saw them as a way to encourage Oregonians to reach new heights. She never expected state agencies to be judged by how well they did in actually achieving the targets. In essence, the purpose of the benchmarks changed between 1990 and 1996. What had been a vision became a tool for holding state agencies and others accountable for results. The targets had to change to do that.

An alternative, and perhaps more appropriate, way to judge Oregon's success over the last decade is to compare the state's progress to that of the rest of the nation. This approach is more in keeping with traditional "benchmarking" and avoids the problems inherent in setting targets ten years into the future. By this standard, Oregon was average (see table 2). The state outperformed the nation on five measures: increased immunization of two-year-olds and reductions in cigarette use by adults in general, smoking by pregnant women, use of illicit drugs by eighth-graders, and infant mortality. Oregon fell short of the national rate of improvement on five other measures: expanded health insurance and early prenatal care and reductions in the teen birth rate, eighth graders' use of alcohol, and child abuse and neglect.² It should be noted that Oregon's most recent rate was superior to the U.S. average in seven of ten cases.

TABLE 2. CHANGING HEALTH STATUS, OREGON AND UNITED STATES, 1990 TO PRESENT

Benchmark	Where Oregon was in 1990	Where Oregon was in most recent year reported**	Oregon percent change 1990 to most recent	Where U.S. was in 1990	Where U.S. was in most recent year reported*	U.S. percent change 1990 to present	OR vs. U.S.: Which performed better over last decade?
Percentage of Oregonians without health insurance ¹	12.5	14.6	+16.8	13.9	15.5	+11.5	U.S.
Percentage of babies whose mothers had early prenatal care ²	76	81	+6.4	76	83	+9.8	U.S.
Infant mortality per 1,000 live births ³	8.3	6.0	-27.7	9.2	7.2	-21.7	OR
Percentage of two-year-olds adequately immunized* ⁴	67	80	+19.4	75	78	+4.0	OR
Percentage of adults who do not smoke tobacco ⁵	78	79.3	+1.6	77.0	76.8	-0.3	OR
Birth rate to females aged 15-19*** ⁶	54.9	46.5	-15.3	62.1	49.6	-20.1	U.S.
Percentage of infants whose mothers did not use alcohol	95	98	+3.2	na	na	na	na
tobacco ⁷	77.7	85.5	+10.0	81.6	87.7	+7.4	OR
Percentage of eighth-grade students who report using:							
Illicit drugs	14	14	0	6	12	100	OR
alcohol	23	26	+13	25	22	-12	U.S.

*in the previous month

in the previous month							
Number of children under 18 abused or neglected per 1,000 ^a	11.3	12.2	+8.0	13.4	11.8	-13.6	U.S.

* Data for 1994. ** Data for 1999 or 2000. *** Data for 1991.

1. U.S. Census Bureau, Current Population Survey, *Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1987 to 1999*, September 20, 2000; available at <http://www.census.gov/hhes/hlthins/historic/index.html>. The percentages of Oregonians who lack health insurance on Tables 1 and 2 differ. Table 1 uses data from the Oregon Population Survey. Table 2 uses the Current Population Survey of the U.S. Bureau of the Census. There has been a long-standing dispute between the state and federal governments on the size of Oregon's uninsured population. For a discussion of the differences and the debate, see "Varying Rates of Uninsurance Among Oregonians: A Critical Comparison of Two Household Surveys," Office of Oregon Health Plan Policy and Research, October 2000.
2. Centers for Disease Control and Prevention, National Center for Health Statistics, *National Vital Statistics Report*, Vol. 49, No. 1, April 17, 2001, and Vol. 47, No. 18, April 29, 1999. Oregon Department of Human Services, Oregon Health Division, Center for Health Statistics, *Oregon Vital Statistics Annual Report*, 1990 and 1999.
3. Centers for Disease Control and Prevention, National Center for Health Statistics, *National Vital Statistics Report*, Volume 49, Number 6, August 22, 2001. Centers for Disease Control and Prevention, National Center for Health Statistics, *Birth, Infant Mortality, and Life Expectancy: 1980-1998*; available at <http://www.cdc.gov/nchs/ssbr/023tab.htm>. Oregon Department of Human Services, Oregon Health Division, Center for Health Statistics, *Oregon Vital Statistics Annual Report*, 1990 and 1999.
4. Centers for Disease Control and Prevention, *Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State*, U.S. National Immunization Survey, 1994-2000. Certificate Base Survey, Oregon Department of Human Services, Oregon Health Division, 1994.
5. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Behavioral Risk Factor Surveillance System, *Trend Data 1990-1999*.
6. Centers for Disease Control and Prevention, National Center for Health Statistics, *National Vital Statistics Report*, Volume 49, Number 1, April 17, 2001, Table 10, "Number of Births, Birth Rates, Fertility Rates, Total Fertility Rates and Birth Rates for Teenagers 15-19 Years by Age of Mother: United States, Each State and Territory, 1999." *National Vital Statistics Report*, Vol. 48, No. 6, April 24, 2000, Table 2, "Birth Rates for Teenagers 15-19 Years, by Age Group and State and Territory, and Percent Change by Age, 1991-98."
7. Centers for Disease Control and Prevention, National Center for Health Statistics, *National Vital Statistics Report*, Volume 49, Number 7, August 28, 2001, Table 4, "Percent of Mothers Who Smoked During Pregnancy by State and Percent Change Between 1990 and 1999: Specified Reporting Areas and Each State, 1990 and 1996-1999." Oregon Department of Human Services, Oregon Health Division, Center for Health Statistics, *Oregon Vital Statistics Annual Report*, 1990 and 1999.
8. Oregon Department of Human Services, Office of Alcohol and Drug Abuse Programs, *Oregon Public School Drug Use Survey, 1990-2000*, and *Oregon Healthy Teens Survey-2000*. University of Michigan, Survey Research Center, Institute for Social Research, *Monitoring the Future Study-1990-2000*.
9. U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Youth and Families Children's Bureau, *10 Years of Reporting, Child Maltreatment 1999*. Oregon Department of Human Services, Oregon State Office for Services to Children and Families, Research Unit, *Child Abuse and Neglect Report*, 1990 and 2000. Children and Families, Research Unit, *Child Abuse and Neglect Report*, 1990 and 2000.

Thus a purely quantitative case cannot be made for the superiority of Oregon's approach. Nor can a case be made that Oregon's performance would have been average in comparison to the rest of the United States even without benchmarking. Perhaps it would have been much worse. Without controlling for the myriad external influences affecting Oregon and other states, the effect of the benchmark program on particular health measures during the decade cannot be determined.

Extensive interviews and focus groups conducted as part of this study clearly show that Oregon leaders believe *Oregon Shines* and the benchmarks have significantly affected health outcomes. As one observer put it, "The benchmarks are like the wallpaper in a room. You might not be aware of them every minute, but they are always there in the background."³ The effect of *Oregon Shines* on the behavior of Oregon leaders, as they try to create and use new tools to improve life in Oregon, is the truly interesting part of this story.

Benefits of the Oregon Approach

A strategic planning process like Oregon Shines, focused on results, is well suited to health issues.

The use of performance indicators was an integral part of the culture and practice of the health community, in Oregon and in the rest of the world, long before benchmarks. State and county health officials hardly needed the Oregon Progress Board to tell them of the importance of collecting and analyzing data on infant mortality, teen pregnancy, and childhood immunizations. If the Progress Board and the benchmarks disappear tomorrow, health officials will still measure, monitor, and mobilize resources to deal with these and other health issues.

What distinguishes the Oregon benchmarks from similar data-gathering enterprises, and what should make them of interest to officials in other states, is the comprehensiveness of the Oregon model, which incorporates social, economic, educational, and cultural indicators. Health indicators are an integral part of a broad system, based on outcomes, of monitoring progress toward a desired future. The health of Oregonians (see box 1) is not only valuable in its own right but is essential to other important values, including a well-educated and well-trained population and a robust economy. One of the many political lessons to be learned from the Oregon experience is that state and county health officials report that they gain enhanced political visibility for their health agendas by emphasizing the broad social value of health. This is especially true at the county level, where public spending on health usually runs a distant third behind spending for jails and roads. By linking health to a comprehensive set of indicators and targets, health officials may gain unexpected allies.

BOX 1. HEALTH BENCHMARKS

The Oregon Progress Board and the Benchmark Reports have no separate category for health. They put health-related benchmarks under the category of Social Support Benchmarks. For purposes of our report, we use a fairly conventional definition of “health.” Thus we include measures such as infant mortality and immunization rates but not other health-related benchmarks like carbon monoxide emissions and safe drinking water.

The following are what we consider “health benchmarks” that appear in *Achieving the Oregon Shines Vision: The 2001 Benchmark Performance Report*, March 2001.

- Teen Pregnancy (births and abortions per 1,000 females aged 10 to 17)
- Prenatal Care (percentage of babies whose mothers received early prenatal care)
- Infant Mortality (infant mortality rate per 1,000 live births)
- Immunizations (percentage of two-year-olds who are adequately immunized)
- HIV Early Diagnosis (annual percentage of new HIV cases with an early diagnosis)
- Adult Nonsmokers (percentage of adults who do not currently smoke tobacco)
- Premature Mortality (years of life lost before age 70 per 1,000 persons)
- Perceived Health Status (percentage of adults who consider their health “very good” to “excellent”)
- Alcohol and Tobacco Use during Pregnancy (percentage of infants whose mothers used alcohol or tobacco during pregnancy)
- Teen Substance Abuse (percentage of eighth-graders who abuse alcohol, drugs, and cigarettes)
- Child Abuse and Neglect (number of children abused or neglected per 1,000 persons under 18)
- Health Insurance (percentage of Oregonians without health insurance)

The benchmark process inspires a more informed, sophisticated public debate on important health issues.

Despite the health community's long-standing use of health-related standardized indicators, many facts about Oregonians' health were either unknown or only irregularly monitored prior to the benchmarks. A former administrator of the Office for Oregon Health Plan, Policy and Research explained that ten years ago policymakers were literally guessing how many Oregonians were uninsured, who they were, and where they lived. The health policy debate today is anchored more in fact and less in anecdote. County health departments and boards of county commissioners now know, for example, the nature and extent of local teen pregnancy problems.

In addition, although the benchmarks are not widely known to the general public, they are very familiar to community activists and leaders. Members of local chambers of commerce, Rotary clubs, and the clergy throughout Oregon often know precisely where their county ranks on teen pregnancy, prenatal care, alcohol abuse, and so on. This information is the prerequisite for community mobilization around these issues. In fact, the two most common words used by state and local people interviewed for this study to describe the utility of the benchmarks were "focus" and "priorities." Especially at the local level, benchmarks help to identify and draw attention to the most pressing community health problems. Furthermore, local public health officials report that important issues, such as teenage pregnancy or immunization rates, get more attention because they are part of a statewide agenda and a larger vision of well-being.

Since they are based upon objective data and analysis, the benchmarks now tend to be viewed in nonpartisan terms, despite some early political controversy, thereby facilitating collaborative efforts. Once the various players agree that a problem exists, they can address it in ways that are most compatible with the internal values of their own organizations or groups. Moreover, players in both the public and private sectors gain new perspectives on issues of shared concern. One prominent corporate leader explained that a major benefit of the *Oregon Shines* planning process is that it has helped everyone involved make new connections outside their normal circle of partners.⁴

"Outlier shame" is a strong motivational and mobilizing device.

As part of their catalytic function, the benchmarks serve as a strong motivational device when used for comparisons among counties across the state. This is especially true when comparisons produce "outlier shame." For example, the health administrator of one rural county explained that he would get little reaction from the local Rotary Club if he told its members that the county's pregnancy rate among females aged 10 to 17 was 32 per 1,000. However, members become more attentive and more likely to act when he tells them that the most urbanized county in the state, Multnomah, has a rate lower than theirs.⁵ Similarly, the director of the Washington County Department of Health and Human Services explained that the benchmarks are valuable because they allow her to make comparisons. "There is an inclination to compare yourself [to others]. It is part of human nature. Are we better or worse than they are? In order to answer that question it is a little more politically interesting for politicians to say, 'Gee, if we are fourth from the bottom in the state, why is that?' The benchmarks give us some leverage. I think we have raised the bar a little in terms of political interest and the interest of the community."⁶

The Progress Board played a key role in the stimulating such comparative county analyses. In November 1997, the Board first published its *Oregon Benchmark County Data Book*, which ranked all 36 Oregon counties on each of the 27 benchmarks for which county-level data were available. For the first time, in a single document, officials could see exactly where their counties ranked in the state as a whole and in relation to other counties. Virtually every county official with whom we spoke mentioned the comparative data as perhaps the most important contribution of the Progress Board and the benchmarks—and one that local newspapers love to report.

Public-private collaboration works best at the local level.

Although the best-known aspect of the benchmarks is their statewide application, some of the most exciting, innovative, and potentially effective uses of them are occurring at the county level. It is at this level that one of the most important theoretical advantages of the benchmarks—the use of public-private collaborations to solve social problems—has been most fully realized. To the extent that county and regional programs improve health, they improve statewide outcomes in turn, and are reflected in the benchmark data.

A SHORT HISTORY OF OREGON SHINES AND THE BENCHMARKS

By the mid-1980s Oregon was emerging from a devastating recession. In the 1986 gubernatorial election, Democratic candidate Neil Goldschmidt used "The Oregon Comeback" as his campaign theme. Goldschmidt, a former Portland mayor and Carter-administration secretary of transportation, promised Oregonians a strategic economic vision to guide them out of the doldrums and into the 21st century.

Goldschmidt was elected and in June 1988 made good on his campaign pledge by personally enlisting the aid of nearly 200 business, labor, education, and government leaders to help "plan a strategy for Oregon's development [over] the next two decades." The result was *Oregon Shines: An Economic Strategy for the Pacific Century*, released in May 1989. It outlined an economic development strategy to: (1) transform Oregon's population into a world-class, 21st-century workforce; (2) create an "international frame of mind" to position Oregon as the gateway to the Pacific Rim; and (3) emphasize the comparative economic advantage of Oregon's extraordinary environmental amenities.

In July 1989 the legislature created the Oregon Progress Board to act as steward of the state's strategic vision. The Board's job was to monitor and report on the implementation of the *Oregon Shines* strategic vision as measured by the benchmarks. The Board consists of 12 members: the governor who chairs it, nine citizen members reflecting the geographic breadth and cultural complexity of the state, and two legislators appointed by the legislature. In addition, two ex officio members sit on the Board: a student representing higher education and the director of the state's Department of Administrative Services. Originally housed in the state's economic development department, the Board, which is independent by statute, was moved by the legislature to the Department of Administrative Services in 2001. Day-to-day Board activities are managed by an executive director appointed by the governor.

Oregon Shines and the benchmark system embody two cherished and celebrated traditions in Oregon politics. The first is the pride Oregonians take in their state as "a perennial innovator."⁷ Oregon was the first state to adopt the initiative and referendum process, the first to have a bottle bill, the first to ration health care for its Medicaid population, and the first to legalize assisted suicide. The second tradition is reliance on participatory democracy to initiate, legitimize, or ensure citizen oversight of public policy. The development and implementation of *Oregon Shines* exemplify both traditions. Oregon is generally acknowledged to be "on the cutting edge of results-driven government."⁸

From its inception the Progress Board has engaged Oregonians in developing the benchmarks. The Board has two primary ways to interact with the public regarding benchmarks and targets. First, community meetings all over the state have been held every six years to review and update *Oregon Shines*. In 1996, more than 500 Oregon community leaders were involved, by invitation, in the review and comment process. Second, the Board holds public hearings on the benchmarks every two years. At that time, anyone is welcome to suggest a change in the benchmarks. Typically the Board hears from about 50 people during each cycle. In most instances testimony comes from agency staff members, experts, and advocates. The advocates often represent the interests of underserved or higher-risk groups.⁹

In 1991 the state Legislative Assembly reviewed and revised a package of benchmarks proposed by the Progress Board, ultimately approving 158 indicators grouped into three categories: exceptional people, outstanding quality of life, and diverse, robust economy. The Board designated 17 of the 158 indicators as "lead benchmarks" and "key" state problems "in which we must see progress in the next five years." Among the health-related "lead benchmarks" were teen pregnancy, drug-free babies, drug-free teens, and improved economic and geographic access to health care.¹⁰

The nature, number, and content of the benchmarks have occupied a good deal of the attention of both the Progress Board and interested parties for much of its history. Criteria for selecting the benchmark targets have been particularly troublesome. "Should the goals be based on the kind of society they really wanted to see? Or should they be based on some kind of 'realistic' appraisal of what might be done, given limited resources and other constraints?"¹¹ In the early years, the Board used inspirational criteria—or what the current executive director (and coauthor of this report) calls the "by God" method, as in: "By God, every two-year-old in Oregon will be adequately immunized by the year 2000!" As the data in table 1 and subsequent revisions by the Board suggest, this method produced targets that were often highly unrealistic and unattainable. This approach also caused confusion among some state policymakers who initially understood the targets to be actual policy goals rather than an inspirational message. Lastly, Governor Kitzhaber understood that progress toward these lofty targets would be affected by the law of diminishing returns. That is, marginal improvements in reaching a goal like adequate prenatal care for 99 percent of all pregnant women in Oregon would be prohibitively expensive.¹²

Box 2 provides a complete history of the Oregon Progress Board and the benchmarks. The history can be divided into three overlapping periods: high hopes; disillusionment; and rebuilding.

BOX 2. PROGRESS BOARD TIMELINE

- 1989 *Oregon Shines* published.
Progress Board created as *Oregon Shines*' steward (SB170).
- 1991 Legislature adopts Oregon benchmarks as state policy (SB 636).
First benchmark performance report issued.
Legislature requires Workforce Quality Councils to adopt benchmarks (HB 3133).
Sweeping K-12 education reform act requires progress towards benchmarks-based standards (HB 3565).
Legislature creates Key Industries Program based on *Oregon Shines*' recommendations (SB 997).
Results-oriented *Human Investment Partnership* published.
First local progress board formed in Baker County.
- 1992 Governor requires state agencies to link budgets to benchmarks; assigns interagency teams to develop "budget packages" for priority benchmarks.
- 1993 Second benchmark performance report issued.
State's welfare reform initiative tied to *Oregon Shines* and benchmarks.
Benchmark-based planning built into performance measurement and budget policy (SB 1130).
Newly created Oregon Commission on Children and Families uses benchmarks extensively in state and local planning (HB 2004).
- 1994 Progress Board co-convenes Livable Communities initiative.
Clarifying Oregon's Fiscal Choices uses benchmarks to identify state priorities.
Oregon Option memorandum of understanding signed.
Progress Board receives Harvard University/Ford Foundation Innovations in Government Award.
- 1995 Legislature allows Progress Board to sunset.
Governor issues executive order recreating the Progress Board.
Third benchmark performance report issued.
- 1996 Benchmarks recognized in Al Gore's *The Best Kept Secrets in Government*.
- 1997 *Oregon Shines II* issued.
Legislature makes Progress Board permanent (SB 285).
First *Benchmark Blue Book* identifies links between agencies and benchmarks.
First *County Benchmark Data Book* issued.
Governor's Social Support Investment Work Group uses benchmarks to frame issues.
Progress Board representative testifies before Congress.
- 1998 Federal Workforce Investment Act requires high-level outcomes similar to benchmarks.
- 1999 Fourth benchmark performance report issued.
Progress Board required to evaluate outcomes in new local planning process for children and families (SB 555).
Key Industries Program sunsets.
- 2000 Progress Board publishes *Oregon State of the Environment Report 2000*.
- 2001 Legislature moves Progress Board to Department of Administrative Services, defines performance management role for Progress Board, and adds legislators to the Board (HB3358).
Fifth benchmark performance report issued.
- 2002 Department of Administrative Services incorporates Progress Board performance guidelines into 2003–05 budget instructions.

High Hopes

When Governor Goldschmidt chose not to run for reelection in 1990, the recently issued *Oregon Shines* was in danger of becoming the classic study that sits on a shelf collecting dust. However, his successor, Governor Barbara Roberts, enthusiastically supported the project. The 1990 election was noteworthy for another reason: Oregonians approved Measure 5, a property tax limitation initiative that forced the state to pay a larger share of public school funding, leaving fewer resources for other state programs and services.

The evolution of the benchmarks and the passage of Measure 5 intersected in 1992 when Governor Roberts prepared her 1993–95 budget. The property tax limitation caused a 15 percent cut in funding for state programs other than education. Governor Roberts ordered cuts in all state agency budget requests but allowed restoration of part of those cuts if agencies linked their requests to specific benchmarks. The governor herself described one result: "Agencies of government who hadn't been paying enough attention to the benchmarks suddenly took the benchmark documents, and they became dog-eared while those agencies searched for things in the benchmarks that applied to their work."¹³ The 1993–95 budget, which proved less draconian than anticipated because of an improved state economy, also created a newfound appreciation for the benchmarks and a desire to be linked to them. As one business leader said, "If you didn't have a benchmark, you weren't worth measuring, and if you weren't worth measuring, maybe your issue wasn't important to people. Everybody who had an issue or was involved in any aspect of public life started beating the door down [to get a benchmark of their own]."¹⁴

As a result the number of classifications within categories and the length of the benchmark report increased dramatically—from 158 benchmarks in 1991 to 272 in 1993. At the same time, advocates for segments of the population like minority groups and the elderly pressured the Board to highlight their particular issues. Consequently the 1995 report became so long that it required an index to find a benchmark on a particular issue.

Disillusionment

The 1995 legislative session was difficult for the Progress Board. Although the legislature appropriated funding for the Board, its authorizing statute was allowed to sunset. The newly elected governor, John Kitzhaber, had to rescue the Progress Board by recreating it through executive order.

Like Tolstoy's families, each legislative opponent was unhappy with the Progress Board and benchmarks in his or her own way. Some argued that, in its desire to satisfy constituents, the Progress Board had adopted so many benchmarks that they no longer served a useful purpose. Others said the unachievable targets left legislators vulnerable to constituent criticism when unrealistic goals were not met. The entire effort was called "a Democratic program with a Democratic agenda."¹⁵

In October 1995 Jeff Tryens became the second executive director of the Progress Board. Tryens received a clear message from legislative leaders. Allowing the Progress Board statute to sunset was a "shot across the bow" that the Board should heed if it wished to survive beyond the 1995–97 biennium.

With the support of key legislative leaders, Tryens set out to mend political fences with legislators while revitalizing support for *Oregon Shines* among business and community leaders. The governor appointed a 46-member blue-ribbon task force that scrutinized the process from top to bottom; involved more than 500 community leaders in updating *Oregon Shines* and the benchmarks; reduced the number of benchmarks from 259 to 92; and prescribed a permanent ceiling of 100 benchmarks.

At the urging of its legislative supporters, the Board and Governor Kitzhaber attempted to make the benchmarks more relevant to the state budget by requiring agencies to show clear links to the benchmarks during budget development. A new report showing those links, the *Benchmark Blue Book*, was unveiled in the spring of 1997.

In the end, the legislative fence-mending, along with the updating of *Oregon Shines* and the culling of the benchmarks, had the desired effect. The 1997 legislature overwhelmingly approved the recreated Progress Board in statute, without a sunset provision.

Rebuilding

The mid-1990s marked a turning point for the Board. Oregonians no longer needed convincing that a comprehensive strategy was necessary to help shape Oregon's future. But if the Progress Board was to succeed in the long run, it would have to be an instrument of public-sector accountability, while keeping an eye on

Oregon's future at the same time.

The Progress Board continues to move toward greater involvement in shaping state government's role in meeting benchmarks. In 2001, the legislature moved the Progress Board to the Department of Administrative Services (DAS), established new responsibilities for guiding agency performance, and added two state legislators to the Board's membership. The move to DAS means that the Board is more closely aligned with state operations and less involved in economic development policy. It also means that the Board is now expected to report to the legislature on how well state agencies are measuring performance related to benchmarks. The legislators on the Board, who are appointed by the Senate president and speaker of the House of Representatives for indeterminate terms, will ensure easier access to the legislature. Finally, *Oregon Shines* will be renewed by the Board every eight years, rather than every six.

USING THE BENCHMARKS

State Agency Budgets and Management

Since 1993 Oregon has attempted to link agencies' performance to benchmark outcomes through the budget process. In that year, agencies were given financial incentives to develop strategies that would affect benchmarks chosen by the governor. In 1995 and 1997, agencies were instructed to develop performance measures linked to the benchmarks. In 1999, Governor Kitzhaber began developing performance measures to be adopted by multiple agencies to assess the results of some high-profile initiatives. For the 2003–05 budget, agencies will be required to: develop performance measures that meet specific criteria; to submit those measures to the Department of Administrative Services for review and comment, but not approval; and to develop a yearly performance report.¹⁶

In addition, state agencies are usually expected to justify their budget requests by linking them to benchmarks before the Joint House and Senate Ways and Means Committee. For example, in its March 2001 budget presentation to the Committee, the state's Medicaid agency, the Office of Medical Assistance Programs (OMAP), listed three main agency goals and the benchmarks to which they were linked. The goal of increased access to health care for low-income Oregonians was linked to "percentage of Oregonians without health insurance."

No aspect of the benchmark process has created higher expectations and caused more criticism than the linkage of benchmarks and budgets. Three criticisms are repeated regularly. First, according to a senior official in the legislature's budget office, with the exception of the extraordinary circumstances surrounding the 1993 budget cycle, no legislative budget decision has ever been based upon benchmark linkages. In other words, no agency has ever been denied funds because it lacked such links or been allocated increased funds because it had them. Fiscal and political considerations, not benchmarks, drive budget decisions.

Second, at least some "creative accounting" occurs when agencies do attempt to connect their budget requests to benchmarks. Some critics maintain that efforts to link an agency's work to benchmarks are often contrived and symbolic, not real. An often-told example of this occurred during the Roberts administration (1991–1995) when agency and department budgets were tied to benchmarks. According to benchmark folklore, the Oregon Arts Commission claimed that it could help reduce teen pregnancy by funding museums to stay open between 4 P.M. and 7 P.M., when teens are most sexually active.

Third, agencies often do not use benchmark data to manage their operations. When asked if the Oregon Health Division (OHD) evaluates offices within the division in this regard, a senior official admitted, "Actually I can't say that is something we are very good at. If there is one thing that I would be critical about in the benchmark process, and the outcomes orientation in general, it's that I don't think we as agencies do as well as we should at holding ourselves accountable for meeting those goals."¹⁷

The irony of this statement is that state health officials are, by training and temperament, predisposed to use performance or outcomes indicators. In fact, OHD personnel have been the Progress Board's staunchest allies within the state bureaucracy, and OHD statisticians and epidemiologists regularly help the Board choose benchmarks, collect data, and, more recently, synchronize Oregon benchmarks with the federal *Healthy People 2010* project. Yet even in the most favorable administrative environments, benchmarks are not part of a true performance-based system, where analysis of results is an integral part of resource allocation and personnel evaluation.

The gap between benchmarks and budget/management stems from the simplistic notion that benchmarks alone can change public managers' behavior. The idea that a vision for Oregon derived from community leaders should be the framework for state agency operations was, and still is, a novel approach to improving government performance. Unfortunately that vision and benchmarks are not nearly enough to ensure improved performance, especially if no revenue increases accompany them.

Oregon recognized this in 1993 when it enacted a law (ORS 291.110) requiring the Department of Administrative Services (DAS) to help agencies develop performance links to Oregon benchmarks. For a variety of reasons, this law was implemented with little guidance or support from the legislature or the DAS after 1995. So the development of measures needed to link benchmarks to day-to-day agency activities occurred sporadically, not systematically.

The realization that no single agency could meaningfully affect a benchmark trend has led some public officials to view "linkages" to benchmarks as quixotic, unrealistic adventures. All parties involved have long recognized this weakness. In recent years, the Progress Board's staff has worked with agencies to develop tiered sets of measures linked to benchmarks, acknowledging that agencies must be judged by measures that they can significantly influence. When the legislature moved the Progress Board to the Department of Administrative Services, it required the Board to develop agency guidelines for linking performance measures to benchmarks. Every two years, the Board is required to report to the legislature how well agencies are implementing the guidelines.¹⁸

Although the Oregon model has avoided the classic performance-based management programs, it fulfills useful policy functions. First, all state agencies related to health policy use benchmark-based performance measures as an internal management tool. The Oregon Health Division, for instance, routinely uses the benchmarks when applying for state and federal grants, writing assessment reports, and developing strategic plans. In addition, the OHD successfully lobbied the Progress Board to make the state benchmark targets conform to those in the federal *Healthy People 2010* project.

The benchmarks also encourage collaboration and coordination within and between state agencies. For example, officials from several health-related departments and agencies worked together to coordinate programs and policies to reduce teen pregnancy. After years of effort, officials have seen the teen pregnancy rate drop dramatically in the past few years—from 18 pregnancies per 1,000 females aged 10 to 17 in 1997 to 13 per 1,000 in 2000. Although this achievement was not solely the result of coordination, at least one OHD official believes that cooperative, focused efforts played an important role.¹⁹

In fact, the gap between agency work and the benchmarks, noted above and cited by critics, may be more apparent than real. The director of OMAP, the state's Medicaid office, initially said, "If the benchmarks were not there, the [Medicaid] program would be pretty much what it is." But he added two interesting points that qualified his statement. First he said, "The benchmarks are broad enough and commonsense enough that what you would want to do in your program anyway lines up very well with the benchmarks." In other words, the health benchmarks incorporate central values held by Oregonians and their policymakers. The benchmarks set targets—like reducing infant mortality, teen pregnancy, children's substance abuse—that most citizens would demand of their government regardless of whether they were benchmarks. Thus even if they are not used to punish the failure to reach targets, benchmarks legitimize and publicize the desired results.

Second, this official's observation reflects a subtle use, rather than a rejection, of the benchmarks. While acknowledging that OMAP tracks outcomes, such as access to health care for the general population and prenatal care for women, he claims that he pays little attention to benchmark targets per se. He is more concerned with making progress than with OMAP's relationship to a target set by the Progress Board. "I don't feel badly that I have not met the standard as long as we are making progress."²⁰ In other words, OMAP does use the benchmarks but not in precisely the way that the Progress Board envisages or prefers.

State legislators, OMAP, the Oregon Health Division, and its parent agency, the Department of Human Services, are all part of common conversation about Oregon's future, a conversation that revolves around the benchmarks. Benchmarks have forced these agencies to focus on problems and priorities that may have existed already but now have greater meaning and direction.

Benchmarks as Bridges

State and Local Collaboration: Commissions on Children and Families

One major philosophical assumption of the benchmark project is that the state is most likely to progress toward the *Oregon Shines* vision if all Oregonians, not just government officials, collaborate. Many collaborations are programs and projects in which benchmarks play a key role. Programs for children and families are a prominent

example.

In 1993 the Oregon legislature enacted HB 2004, which created the Oregon Commission on Children and Families (OCCF) and 36 county-based local commissions. The OCCF's mandate is "to bring together individuals, communities, service groups, and government to work collaboratively, identifying community strengths, concerns, and opportunities," in order to improve the health of the state's children and families, coordinate services to children and families, enhance community involvement, and lead to a better investment of state dollars.²¹ One noteworthy feature of the Commission's work is that it is legally required to identify "outcomes relating to children and families for incorporation in the Oregon Benchmarks."²² Furthermore, both the state and local commissions on children and families (CCFs) must base their program decisions upon outcomes.

Shortly after its creation, the OCCF identified ten benchmarks related to health and development that reflected the most urgent needs of Oregon's children and families. The state commission required each local commission to develop a comprehensive plan to meet these needs—like increased prenatal care and decreased teen pregnancy and child abuse and neglect.

Although the state commission is charged with creating policies and providing administrative and technical support to the local commissions, most work occurs at the county level. Each local commission develops a comprehensive plan to meet general statutory goals by promoting community wellness, local decision-making, and collaborative partnerships, and by measuring results to achieve accountability. Local commissions are funded primarily through grants that are often linked to benchmark targets from the state commission. Local commissions contract for services with local public and private organizations such as county health departments, school districts, community hospitals, religious groups, and private alcohol and drug abuse programs.

As state and local commissions have gained sophistication, they have created measures linked to benchmarks that are better barometers of commission performance than before. This shift reflects continuing concern about, and criticism of, the benchmarks. Local commission officials have expressed frustration at their seeming inability to affect benchmark trends. Problems such as teen pregnancy, child abuse, and substance abuse have complex etiologies that defy simple solutions and that state and local officials can seldom control. Many people involved in CCF work felt that no matter how hard they tried, they were making no obvious headway toward the benchmark targets.

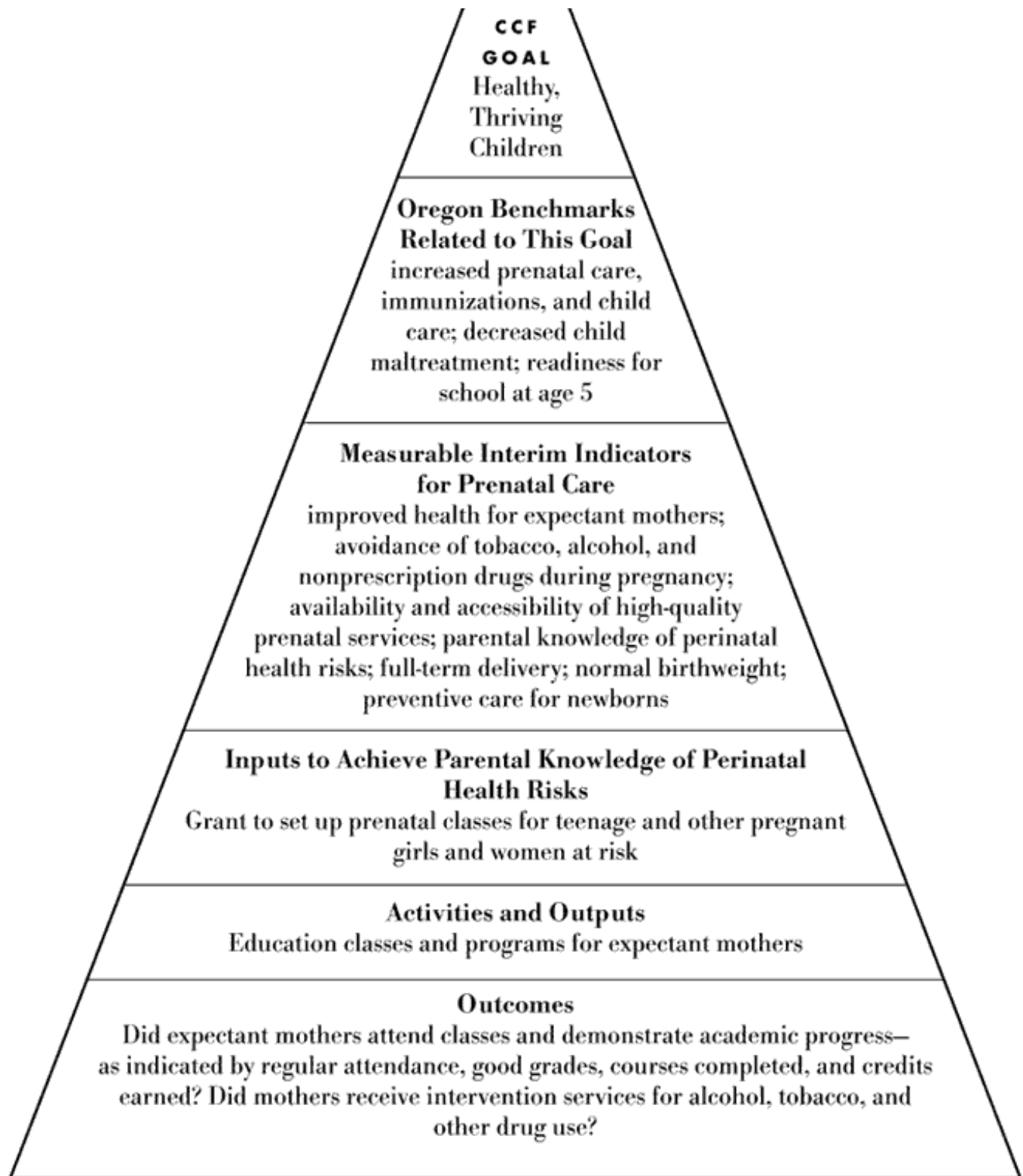
One local CCF official illustrated her preferred approach to solving problems with an example from the area of child abuse and neglect. Her local commission discovered that parents who learn parenting skills are less likely to abuse and neglect their children. The local commission then began to measure people's progress toward acquiring specific parenting skills, like completing an anger management class. The local commission could influence and see results in that kind of progress, rather than worrying about the year-to-year decline in rates of abuse and neglect.²³

Other local directors criticized the state benchmarks even more bluntly, calling them "too global," "lofty," "philosophical," and "ethereal." For these officials, benchmarks proved to be more of an irritant than a useful management tool.

The state commission, to its credit, quickly realized that something would have to be done if high-level outcomes, like the Oregon benchmarks, were to be part of local communities' strategic planning. In 1997 the state OCCF therefore issued a report entitled *Building Results: From Wellness Goals to Positive Outcomes for Oregon's Children, Youth, and Families*. The report identified interim performance indicators that would be stepping stones toward the five goals identified by the state commission as necessary to greater well-being for children, youth, and families. Those goals are: "Strong, Nurturing Families," "Healthy, Thriving Children," "Positive Youth Development," "Educational Progress and Success," and "Caring Communities and Systems." The relationship among these goals, the benchmarks, and the performance indicators and measures is illustrated with the Healthy, Thriving, Children goal (figure 1).

FIGURE 1. LINKING BENCHMARKS AND INTERIM INDICATORS





Source: Based on Pratt et al. 1997, 1998.

For local CCF officials, the advantage of including these interim indicators is clear and compelling. Officials can now document, for instance, annual progress in enrolling pregnant teens in prenatal care, parenting, and preventive care programs even if they cannot show short-term reductions in teen pregnancy. This approach served as the basis for recent Progress Board guidelines developed for state agencies, noted earlier.

County Health Departments

Since 1994 county health departments have been required to develop their annual plans around selected benchmarks. As a result, according to the state's chief health officer, "The benchmarks have substantially changed the way . . . local health departments operate. They have served as a way for public health workers to use and understand data better, to prioritize their health problems, and to increase their involvement in their communities."²⁴ Some counties have gone well beyond what the law requires of them. In Multnomah County, the state's most populous, the health department's plan identifies the "strategic directions, objectives, and strategies" of the department and links them to county health benchmarks. Some of the county's benchmarks are also state benchmarks—such as the percentage of two-year-olds who are adequately immunized, the pregnancy rate per 1,000 females aged 10 to 17, and the availability of adequate early prenatal care. Others are specific to the county and reflect its urbanized or pluralistic population—such as the incidence of tuberculosis and hepatitis B and the number of domestic violence calls to police per 1,000 households.

Another urban county, Marion, uses benchmarks to direct its policy decisions regarding teen pregnancy, which is widely recognized as a problem with profound long-term economic and educational, as well as medical, consequences. Marion County's average teen pregnancy rate for 1994–98 was 23.9 per 1,000 females aged 10 to 17, the third highest in the state. In November 1999 the county's Health Advisory Board, working with the county health department, decided to focus community attention on the problem by issuing a report, *Teen Pregnancy in Marion County*. The report documented the pregnancy rate, not only at the county level but also for each of the county's 33 zip codes. In addition, the report broke down the data by race, ethnicity, age of the mother and father, education level of the mother, marital status, number of pregnancies, and school district. The report, which listed risk factors for teen pregnancy and identified resources for teens in each zip code, was distributed to hundreds of organizations and individuals in the county.

Marion County's teen pregnancy campaign illustrates three major themes relating to the use of benchmarks in Oregon. First, state and county health officials insist that issues such as teen pregnancy, prenatal care, immunizations, and substance abuse are not exclusively, or even predominantly, the responsibility of the public health community. As the administrator of the Marion County health department said, "To improve community wellness is a community effort not a health department thing."²⁵ Second, the role of the health department, in this view, is "to provide leadership and be a catalyst to get the community charged up about doing something about community health problems." Third, the catalytic role of the health department "is much more a data collector and disseminator of information that relates to benchmarks so that we could focus the community's efforts and get people to say 'What have we done around this benchmark?'"

These three themes neatly summarize the theory behind the *Oregon Shines* vision and the benchmarks. The vision articulated in *Oregon Shines* belongs to, and is the responsibility of, all Oregonians, not simply their government. State and local government can act as catalysts to mobilize community action by highlighting problems. Perhaps the most effective way to focus attention is to bring information to the public and policymakers through periodic benchmark or county public health reports.

Spawning Community Vision Projects

The philosophy of community engagement is applied in the benchmark-inspired, community-based, collaborative projects found in several counties. Two examples illustrate the genre.

In Deschutes County, the Central Oregon Health Council consists of about 100 public and private organizations. Its mission is "to promote health and well-being of Central Oregonians" by fostering "interagency collaboration," building on existing programs, and identifying "areas in need of support." Jim Lussier, president of St. Charles Hospital in Bend and the driving force behind the council, reports that the council was created to fill a need for greater cooperation among the 40 to 50 health-related agencies in the region that shared common concerns.

Among the benchmark-related projects sponsored by the council was a "Shots for Tots" immunization program. According to Lussier, the health council was drawn to the issue of immunization because the Progress Board designated it as a "key" state benchmark.²⁶ Although the Board does not collect county-level immunization data, the Deschutes County Health Department has immunization records for children care for in its clinics. In 1996, for example, 65 percent of those children were adequately immunized, a rate well below the Progress Board's statewide goal at that time of 90 percent. As a result the Central Oregon Health Council, in cooperation with the county health department and the Rotary club, developed the "Shots for Tots" program, which offers free immunizations at various locations in the county three times a year. In 1999, the most recent year for which county health department data are available, the immunization rate for children seen in the health department had increased from 65 to 75 percent. Obviously, the program has had a practical impact.

Beyond that, council officials acknowledge that it is difficult to judge whether merely disseminating information about local health indicators ultimately improves health. But at least the region now has a more enlightened group of community leaders who are in a position to instigate changes in behavior and allocation of resources.

A second locally based, outcomes-oriented project inspired by state benchmarks is the Healthy and Sustainable Communities Project (HSCP) of Jackson and Josephine Counties in southern Oregon. The project began in 1994 and has progressed sporadically through a number of stages, involving hundreds of people in a series of forums, planning groups, and roundtable discussions. Between January and June of 1997, 500 people participated in a series of meetings to identify common values and hopes for the county's future and to recommend steps to achieve an agreed-upon vision. The result was a 50-year vision plan called *Blueprint for the Future*, the regional equivalent of *Oregon Shines*. It covers eight categories, one of which is health and human services. *Blueprint* identifies a *preferred future* in which citizens "believe in personal and collective responsibility for health" and "to the extent possible there should be equality of care." *Values* include "universal access to reasonable health and human services." *Actions* include moving to "identify existing health and human service provider networks" and to "involve the business community in the volunteer service program."²⁷

The next step was to study "quality of life indicators" in order to provide community leaders and citizens with information by which to measure their progress in each of the eight categories. In January 2000 more than 100 community leaders met to discuss "Measuring Livability in Southern Oregon." In March 2001 the Rogue Valley Civic League issued its *Quality of Life Index: Livability Indicators for Jackson and Josephine Counties*. The report listed 40 indicators, including low birthweight infants, substance abuse by youths, early breast cancer diagnosis, health insurance coverage, and years of life lost. For each indicator, the report compared Jackson and Josephine counties to state averages. Like the state benchmarks, the southern Oregon indicators are supposed to be catalytic. "The next step is putting these indicators into action. Elected officials and citizens alike can use this information to make decisions that will positively impact the future livability of our communities."²⁸

From its beginning, the livability project received inspiration and technical assistance from the Oregon Progress Board. According to one project leader, "The whole format of this is around what the Progress Board was doing. If the state isn't looking forward, then it is almost impossible to get a region like this to raise the money and keep the organization together to try to keep this going."²⁹

Summing Up

State and local government, as well as community organizations, have used the benchmarks and the benchmark process to organize administrative activities like budgeting and strategic planning, to mobilize communities and resources, and to initiate health-related programs. It is impossible to determine whether these efforts have improved Oregonians' health, because the issues are complex and the programs are new. But at a minimum they have produced better-informed civic leaders and citizens.

A TALE OF THREE BENCHMARKS

Childhood Immunizations

During a White House ceremony in December 1994, federal and state officials signed a Memorandum of Understanding (MOU) that committed them "to encourage and facilitate cooperation among federal, state, and local entities to redesign and test an outcomes-oriented approach to intergovernmental service delivery."³⁰ The agreement, called the Oregon Option, grew directly from the benchmarks and illustrates that the system plants seeds and acts as a catalyst. Lisbeth B. Schorr, a Harvard social policy analyst and author, has described the Oregon Option as: "probably the greatest accomplishment so far of the Oregon Benchmarks process . . . an unprecedented marriage between a federal government bent on reinvention and a state that was ready."³¹

According to one official involved with the Oregon Option, the essence of the understanding was that "they [the federal government] give us flexibility. We give them accountability."³² Rather than being a specific program or policy, the Oregon Option is a way of doing business among state, local, and federal agencies. "It is an agreement to work together."³³ In effect, the federal government promised to waive burdensome regulations, reduce paperwork, and simplify funding requests. In return Oregon would document its use of federal funds to achieve certain performance standards—the benchmarks. The MOU singled out Oregon as "uniquely suited" for this kind of pilot program because it already had an accountability mechanism, the benchmarks, in place.

The process began with a meeting of more than 100 state, local, and federal officials in Portland in September 1994 in which participants agreed to cooperate on three "clusters" of issues: healthy children, the workforce, and

family stability. Participants identified the appropriate state, local, and federal officials and agencies that should be partners for each cluster.³⁴ The cluster partners, in turn, established a set of priorities, including nine state health benchmarks, and identified childhood immunizations as one of the state's most serious health-related needs and one on which they wanted progress made speedily, within one or two years.

In 1994 only 53 percent of two-year-olds in Oregon were immunized, well below the national average of 69 percent. From the perspective of state and local officials, federal programs inhibited rather than facilitated immunization. As one state participant explained, "We get federal money to immunize kids. That's a great idea, but it's not that simple. There are six different kinds of federal immunization money."³⁵ In addition, physicians complained that vaccines supplied under the various federal programs came in different doses, further complicating their work and discouraging their participation in immunization efforts. Working together, members of the healthy children cluster obtained federal waivers of a number of regulations related to immunization, including one requiring competitive bidding; the six funding streams were consolidated, and "permission [was obtained] from the Social Security Administration to use a child's Social Security number as a common identifier for the statewide immunization registry. . . ."³⁶

In a July 2000 interview, one Oregon Option leader was asked about the healthy children cluster and the state's progress on immunizations. Her response is both revealing and sobering. With regard to the cluster she said, "We're still in existence, but we don't meet." Perhaps even more troubling was the fact that the state ranked 49th in the nation on childhood immunizations and that little progress on immunization had been made since 1996, despite the much-ballyhooed Oregon Option and the healthy children cluster: Between 1996 and 1999, the rate increased only from 67 to 73 percent, well short of the 100 percent benchmark target for 2000. In 2000 the rate jumped from 73 percent to 80 percent, vaulting Oregon to 20th among the states.

This information prompts questions about the current status of the Oregon Option and the lessons others can learn from Oregon's experience with benchmarking and childhood immunization. Depending upon whom one asks, the option has either atrophied because of neglect by the Kitzhaber administration or has taken a new, more meaningful form because of the efforts of the Kitzhaber administration.

Critics who believe the Kitzhaber administration "dropped the ball" on the Oregon Option claim that the governor never appreciated the importance of personal relationships among state and federal officials and did not do enough to cultivate or sustain them. According to one interviewee who signed the MOU and who expressed utmost respect for the governor, the result is a perception that the Kitzhaber administration "has been less engaged in this process." In this view, the Option has "withered."

Governor Kitzhaber characterizes his attitude and his administration's actions quite differently from such critics. He believes that he and his staff "were supportive of the Oregon Option from day one" and that he had a good working relationship with key federal actors in the process, including Vice President Al Gore and Secretary of Health and Human Services Donna Shalala. Moreover, the governor contends that much of what his administration has done in this and other policy areas directly reflects on the Oregon Option.³⁷

The Kitzhaber administration makes a compelling argument that the spirit of the Oregon Option is alive and well. In this view, the Option has become the preferred way of dealing with other local and federal, as well as tribal, governments. An aide to Governor Kitzhaber explained that the option: (1) serves as a model of intergovernmental partnerships; (2) delegates authority to the lowest level of government; (3) reduces the burden of regulatory authority; (4) grants greater flexibility to local governments; and (5) requires measurable public accountability. It is, she explained, "this governor's way of doing business. His way of problem solving."³⁸

Two recent activities show that the Option remains relevant within the Kitzhaber administration. The first was the Oregon Option Celebration, a meeting on March 15, 1999, convened and hosted by the governor. His remarks explained what the Option means to him. "We are here today because we believe in collaboration and the empowerment of individuals to make decisions about how to address their own needs and be accountable for results." Governor Kitzhaber spoke of policymaking "that stresses partnership and problem-solving, not conflict, power, and the confines of programs."³⁹

The relevance of the Oregon Option was also illustrated when the Governor's Mental Health Alignment Work Group issued its final report in January 2001. The work group had been "charged with analyzing gaps and redundancies in existing mental health treatment and services in Oregon. It was to recommend the most efficient means of coordinating and delivering mental health services in Oregon with a particular focus on state services."⁴⁰ The work group found problems remarkably like the immunization problem identified by the healthy children cluster. It discovered that approximately 13 separate, autonomous state agencies or divisions were providing mental health services amid an incredibly fragmented array of regulations, funding mechanisms, client screening, contractual obligations, and reporting requirements. "Because Oregon's mental health system is disjointed and overwhelmed, consumers and families do not always receive the most clinically appropriate

service," said the report.⁴¹

The work group recommended that state agencies "develop or adopt nationally recognized system-level performance measures linked to Oregon benchmarks for state-level monitoring and reporting for both children and adults." The report also proposed collaborations among state and local agencies and between the public and private sectors, as well as reduced bureaucratic hurdles and redundancies to permit easier, faster access to mental health services. As a Kitzhaber aide explained, the benchmarks are valuable because they serve as a rallying point that encourages diverse agencies, organizations, and individuals to work together, then to measure their progress, and finally to hold themselves accountable.⁴² This approach is the Oregon Option in everything but name.

The story of the Oregon Option is instructive. Properly understood, the option is a model of policymaking that reflects the benchmark philosophy. Subordinate levels of government can exercise regulatory or fiscal flexibility in return for greater accountability based upon measurable results. Although the option, as a formal agreement between levels of governments, has all but disappeared, the process it embodied has become standard operating procedure in the governor's dealings with other governments, a process entirely consistent with the benchmark model.

What lessons then, can others learn from Oregon's experience with benchmarks and immunization rates? The state immunization rate improved substantially over the decade, moving from 67 percent in 1990 to 80 percent in 2000—an increase five times greater than the U.S. average. This improvement came in two "spurts." In 1995 rates jumped from 67 percent to 74 percent. Despite that increase Oregon was languishing in 49th place among the states by 1999. Only a dramatic jump from 73 percent to 80 percent between 1999 and 2000—saved Oregon from an abysmal performance on this benchmark.

State health officials attribute the remarkable turnaround in 2000 to a computerized statewide immunization system called ALERT, which keeps track of every child's immunization record. First proposed in 1994, ALERT has been gradually implemented over several years. In 2000 the state health department began sending patient-recall reports to health care providers and reminder notices to parents.

As immunization demonstrates, benchmark-related changes in health policy and the public health outcomes that result are often slow to bear fruit. Several years passed before efforts to increase immunization "ripened."

Early Prenatal Care

Early prenatal care is universally acknowledged as critical to the beginning of life. Early prenatal care is important not only in preventing low birthweight but in perinatal health and in identifying pregnant women at risk. In addition, according to the Progress Board's *2001 Benchmark Performance Report*: "Studies have shown that for every \$1 spent in first-trimester care up to \$3 can be saved in preventable infant and child health problems."⁴³ In 1990 one-fourth of Oregon babies were born to women who had had inadequate first-trimester prenatal care.

During the 1997–98 Oregon legislative session, the executive director of the Progress Board, Jeff Tryens, was asked by the chair of the House Committee on Human Resources to provide an overview of the benchmarks that applied to her committee's legislative jurisdiction. Tryens reported that the state's rate for adequate prenatal care was only 81 percent, well short of the 1995 target of 95 percent. The committee chair asked Tryens to find out why the state had not made better progress. Tryens called the Office of Health Statistics of the Oregon Health Division. The response to his question was: "We will have to get back to you." Tryens was somewhat surprised by this answer, because he assumed that the OHD staff would, on its own, have looked into why the state was doing so poorly on such an important health measure.

A few days later, Tryens got answers from the health officials. First, he was told, the 1995 target of 95 percent was unrealistic. Second, because state funds were meant for low-income women, the many middle- and upper-income pregnant women who do not choose to get adequate prenatal care were not being reached. Third, no single state agency had overall responsibility for this benchmark. When Tryens asked how state government could improve Oregon's performance, officials suggested that it (1) increase outreach to all pregnant women; (2) expand availability of care to lower-income women; (3) improve access to prenatal care through systemic changes in managed care, for example by making prenatal care a mandatory benefit; and (4) make the Oregon Health Division the lead agency for this benchmark.

Tryens attempted to verify the OHD's assertion that the 1995 target was unrealistically high by finding out which states were most successful in early prenatal care, why they were successful, and what target was reasonable. He discovered that the most successful states in the country—Maine, Massachusetts, and Rhode Island—were achieving a rate of around 90 percent. Officials in those states attributed their success to programs in which all pregnant women or all women pregnant for the first time receive home visits from a public health nurse or other

health care provider. Based on the recommendation of the Oregon Health Division, the Progress Board lowered the 2000 state target to 90 percent, knowing that Oregon had little chance of achieving even that level without more aggressive outreach. Despite the more modest goal, the state did not achieve its target in 2000.

The Health Division agreed in 1997 to implement the changes it had said were necessary and assigned a full-time staffer to the task through a recently acquired federal grant. In 2001 Governor Kitzhaber received funding from the legislature for a comprehensive Children's Plan that focuses on early childhood outcomes, including adequate early prenatal care.

This case illustrates several important points about benchmarking. First, targets matter. In its formative years, the Progress Board's target setting was governed more by exuberant aspirations than scientific analysis and realistic expectations. In 1990, as table 1 shows, the Progress Board envisaged that within ten years all Oregonians would have health insurance, 95 percent of all babies would be born to mothers who had had early prenatal care, and all two-year-olds would be adequately immunized. Such laudable but unrealistic targets invited scorn and frustration.

A second lesson from the case of early prenatal care is that politics trumps even realistic targets and good intentions. Oregon could almost certainly increase its prenatal care rate with more educational outreach or with universal home visits. The state has multiple home-visit programs for pregnant women. But they are all voluntary and restricted in scope due to funding limitations and a dominant political culture that resists the idea of a "government bureaucrat" coming into a woman's home to counsel her. Benchmarking can identify problems, but policymakers must work out the politics of problem solving.

Third, the effects of "good data" are often hard to discern. The governor's Children's Plan was the culmination of years of work by scores of public officials, practitioners, agency staff members, and advocates. The Progress Board staff provided data, public visibility, and advice to the Children's Plan between 1997 and 2001. Was this initiative caused by the disappointing data on prenatal care? Certainly not. Did the Board make an important contribution to the process? Most certainly.

Teen Pregnancy In Tillamook County

In the mid-1990s Tillamook County, a small coastal community in the northwest part of the state, became the poster child for performance-based government and community mobilization around serious social problems. It was celebrated because the county's teen pregnancy rate plummeted from 23.8 births per 1,000 females aged 10 to 17 in 1990 to just 7.1 per 1,000 in 1994. Tillamook went from having the third highest rate in the state to having the lowest.

Teen pregnancy in Tillamook illustrates both the strengths and weaknesses of the benchmark process. By the mid-1980s Tillamook County officials recognized the teen pregnancy problem.⁴⁴ It became part of the county's policy agenda in 1987 when the county Health Department proposed establishing health clinics in the county's high schools. For many Oregonians, "school-based health clinics" is code language for counseling about birth control and distributing contraceptives. The proposal therefore ignited a storm of controversy in Tillamook and was soundly defeated by the school board in a 4–1 vote. Despite its failure, the initiative sparked a community debate over the seriousness of the county's problem.

Tillamook County's success in reducing teen pregnancy involved no "silver bullet." Progress came gradually between 1990 and 1994 as various community groups and civic organizations came together and agreed on two things; they shared a commitment to reduce teen pregnancy, and they agreed to disagree about how to achieve that goal. In effect, the absence of a community consensus dictated a broad-based approach to the problem.⁴⁵ "What emerged were multiple, concerted efforts rather than one grand, comprehensive strategy," according to researchers Luke and Neville. "There were both individual strategies and collaborative strategies, but all aimed toward the same outcome—the reduction of teen pregnancies and other at-risk adolescent behavior." Schools, churches, the local community college, the YMCA, and the business community were all enlisted in an educational and counseling campaign against teen pregnancy. The county health department began a "You First" program in 1991 that gave priority to teens who sought family planning appointments. In effect, any teen who wanted a family planning appointment would be seen within 48 hours.⁴⁶

In 1991 the Oregon Progress Board issued its first benchmark report to the legislature and identified teen pregnancy as a "lead" benchmark, one of the most "urgent problems in which we must see progress in the next five years." With this step the problem of teen pregnancy gained increased importance and publicity within the county and the state. Conversely, public discussions of the Tillamook teen pregnancy problem now routinely included references to the state benchmark, enhancing the sense of urgency within the county. The results in Tillamook were dramatic. As the teen pregnancy rate fell from 23.8 per 1,000 in 1990 to 16.3 in 1992 and 7.1 in

1994, national organizations and national media came to Tillamook to find the secret to the county's success.

The story, unfortunately, does not have a happy ending. By 1995 the rate had more than doubled to 15.7. It followed an erratic path until 1999, the most recent year for which data are available, when it reached 21.0—well above the state average of 15.9. What happened to reverse Tillamook's extraordinary success? Two interrelated forces appear to have been at work. First, the widespread community involvement, energy, and enthusiasm simply waned over time. As one report concluded: "Although teen pregnancy remain[ed] an issue for a few agencies . . . most agencies turned their attention to other issues. Many felt they were succeeding in reducing teen pregnancies and 'were off to fight other dragons' as one program administrator explained."⁴⁷

Part of the dwindling interest may be attributed to a second factor—the loss of key community leaders. Nearly 70 percent of the ministers in the community had moved on to other communities and "the original alcohol and drug prevention specialist assigned to the schools had left."⁴⁸ The head of the county health department at that time now concedes that she was less engaged in, and less able to affect, the process when she moved from the health department to an elected position on the board of county commissioners.⁴⁹ What happened in Tillamook has happened over and over again throughout Oregon communities with similar community- and performance-based programs. Most local programs that we examined have a history of episodic, uneven development during which periods of intense activity and interest alternated with periods when the local programs or initiatives lay virtually dormant. The key ingredient in all of these endeavors has been the presence of committed leaders, as the Tillamook case illustrates.⁵⁰

THE BENCHMARK EXPERIENCE IN OTHER STATES

The early 1990s were a time of the discovery of, and extraordinary enthusiasm for, results- or outcomes-based government in this country. National interest increased dramatically under the Clinton administration with enactment of the Government Performance and Results Act (GPRA) of 1993, which created the Office of National Performance Review (NPR). The GPRA was enacted "to improve the effectiveness and efficiency of federal programs by establishing a system to set goals for program performance and to measure results."⁵¹ Before passage of the GPRA, several states—including Florida, Minnesota, North Carolina, Texas, and Virginia, as well as Oregon—already had performance-based management programs. As a result, the federal government looked to these states to guide its own efforts. For example, in 1994 the General Accounting Office (GAO) conducted a review of state experiments to "identify some of the experiences other governments had in implementing management reforms that have been reported as being successful and, thus, may assist federal agencies as they implement the Government Performance and Results Act of 1993 (GPRA)."⁵²

The early performance-based management reforms varied widely in scope, purpose, and durability. The heart of the movement "to reinvent government" was the conviction that public officials were not paying enough attention to the results of government programs and practices.⁵³ Rather than knowing, for example, how much a state spent on education, how many new classrooms it built, or how many teachers it hired, reformers—and presumably taxpayers—wanted to know how many students were reading at grade level and how they were performing on standardized tests compared to students in other states. Many, indeed most, reforms were aimed at improving the performance of specific state agencies, departments, or offices, rather than embodying a coordinated plan or vision for an entire state.⁵⁴ The closest that most states came to such a coordinated plan to monitor and improve program and policy outcomes was their use of performance-based budgeting (PBB). According to a recent study by Melkers and Willoughby, 31 states have legislation requiring PBB, and 16 others make PBB an administrative requirement contained, for example, in budget instructions.⁵⁵

Oregon's performance-based model is distinguished from the more widely used agency- or program-specific projects adopted by scores of states, and by the federal government under GPRA, by two features. First, the Oregon project grows out of, and is intimately linked to, a long-term *societal* vision of where the state is now and where it wants to be on a broad range of social, economic, environmental, and political indicators. The state's vision is contained in *Oregon Shines* and the follow-up report issued in 1997, *Oregon Shines II*. As a major policy question, this model asks how state resources and agency work can be coordinated in order to realize the state's vision. By way of contrast, performance-based initiatives and programs in other states tend to measure the efforts of individual agencies to reach specific targets for those agencies without reference to broad societal indicators or outcomes. Oregon asks, "How is Oregon doing?" Other states ask, "How is our Department of Environmental Quality doing?"

The second distinguishing feature of the Oregon model is that it is based upon public participation in the formulation of the overall vision and the indicators or benchmarks that are used to measure progress toward that vision. *Oregon Shines*, *Oregon Shines II*, and the various benchmark revisions reflect the systematically solicited views of the general public and interest groups in forums and public hearings held around the state.

The six states that have a system resembling Oregon's typically include one or more of the following four features (see Appendix A). First, each regularly publishes a progress report similar to *Achieving the Oregon Shines Vision: The 2001 Benchmark Performance Report*. Second, performance programs tend to be directed by a lead oversight agency, like Florida's Commission on Governmental Accountability to the People. Third, most states in this group have issued an overall vision statement or specific vision statements. Finally, these states tend to adopt a limited number of benchmarks, measures, or indicators, grouped into six or seven areas such as health, education, citizen and civic participation, the environment, the economy, children and families, and the workforce.

State-level policymaking and administration oriented to results no longer enjoy the high visibility they had in the early- to mid-1990s.⁵⁶ In fact, two state programs that had benchmark programs have ceased operation—Connecticut in 1995 and Florida in 1998—although they remain on the statute books. In Connecticut, disinterest on the part of Governor John Rowland, who inherited the program, doomed it. In Florida, political friction between the governor and the head of the commission was responsible for the program's demise.

Despite this backsliding, the Oregon program continues to attract considerable interest at home and abroad.⁵⁷ Each year the Oregon Progress Board receives scores of requests from state and local governments and private-sector organizations in the United States and other countries for information about the benchmark project and *Oregon Shines*. The Oregon Progress Board Web site received an average of more than 17,000 hits per month in 2000. However, as with other Oregon innovations like the Oregon Health Plan, assisted suicide, and the bottle bill, interest has far exceeded emulation. Although many states have adopted some form of performance-based management, few employ all the features of the Oregon model.

LEARNING FROM OREGON

What can other states and local communities learn from Oregon's experience with its benchmarks? In any assessment of Oregon's benchmarks, its Progress Board, and *Oregon Shines*, we must remember what the agency and program are and what they were never intended to be. As then-governor Neil Goldschmidt said of the newly formed Oregon Progress Board in December 1990, "It is not your typical institution. It has no dollars to appropriate. It will construct no roads or parks or schools. It has no regulatory authority. It will not halt pollution, nor will it order criminals to jail. Yet this Board possesses a power that is equally important: the power of ideas." The goals were vague, inspirational, and naïve. Governor Goldschmidt asked the Progress Board to "dream about the future," to "give Oregon a clear sense of direction," and to "think long term."⁵⁸

Oregon's Evolving System

Much has changed since 1990 when the Progress Board and benchmarks were introduced. Governor Goldschmidt's inspirational, charismatic leadership has given way to the lower-key, program-oriented style of Governor Kitzhaber. The original *Oregon Shines* report was preoccupied with economic transformation and revitalization, while *Oregon Shines II*, a subsequent report issued in 1997, is a more balanced document in which quality-of-life issues play a more central role. The benchmarks have decreased in number and become a more meaningful tool for gauging the "state of the state." The mandate of the Progress Board has been scaled back from the Goldschmidt days, when it was not only supposed to propose measurable goals but "to spell out what we must do to achieve them." In his inimitably exuberant fashion, Governor Goldschmidt called upon the brand-new Progress Board, with its total staff of four, "to tell Oregon what it must do to succeed in the future." That immodest, unrealistic mandate fitted the Goldschmidt management style.

Oregonians have learned a great deal about outcome-based government over the last decade. There is still much to be learned and applied to increase its chances of success in Oregon and elsewhere. We offer the following recommendations for change in the Oregon model.

Improving the Oregon Model

Benchmarks should be connected more closely to management and budget decisions.

Oregon's attempts to link benchmarks to budgets have been marginally successful. The *Benchmark Blue Book* shows the links to benchmarks that agencies themselves describe. As part of budget development and review, agencies are expected to show how they are working to influence benchmark trends. However, agencies need to explain more clearly how they are working toward achieving benchmark targets and what collaborations among agencies and other partners will be required.

Benchmarks could help to set overall priorities for budget decisions. But no systematic analysis of benchmark trends now occurs as part of the state's budget development.

Perhaps the most important missing ingredient today is the lack of consistent involvement by the legislative branch. Unless the legislature uses benchmark data to set priorities and judge success, agencies' interest in further incorporating benchmarks into management and budgeting will not last.

As part of the 2003—05 budget process, the Department of Administrative Services is requiring all agencies to be trained to articulate, in a consistent manner, logic linking their strategies to improving benchmark trends. This is an important next step in establishing practical links between benchmarks and budgeting and management.

The reasons why the state or a county has, or has not, met its targets should be analyzed.

Oregon has carefully monitored state and, to a lesser extent, county progress toward benchmark targets. The state has done less to *explain* progress or the lack of it. It is unclear where such analytical responsibility rests. The Progress Board has done some analysis, as in the case of prenatal care described above. But it is unrealistic to expect a state agency with a staff of three to undertake the extensive analysis necessary to account for benchmark trends. It is, however, reasonable to expect lead agencies, like the Oregon Health Division or its parent agency, the Department of Human Services, to undertake it. Yet, often, such analysis occurs only if it is requested. As we have seen, the OHD could not readily explain why Oregon ranked 49th in the nation on early childhood immunizations or why the state's teen pregnancy rate has steadily declined. In contrast, in the high-profile area of health insurance coverage, particularly Medicaid under the Oregon Health Plan, state officials do know who is uninsured, why they are uninsured, and what is needed to expand coverage.

State agencies should be required to generate a biennial analysis of the state's success or failure in reaching benchmark targets. Legislative involvement and interest in such analysis is critical.

Benchmark data need to be broken down below the county level.

One of the Progress Board's important recent accomplishments was publishing comparative information on the 27 indicators, including all health indicators, for which county-level data are available. In fact, *Governing* magazine has reported that Oregon is leading the country in breaking down data and allowing counties to compare themselves to one another.⁵⁹ However, for health officials in the state's larger counties, this disaggregation has not gone far enough. Although Oregon's population is remarkably homogeneous by national standards, some counties contain substantial diversity. Differences among population groups and neighborhoods within Portland or Salem, for example, are as great as those between counties.

In the more diverse and populous counties, health officials believe that benchmark data must be broken down to the zip code level to be truly useful. A report by the Community Health Information Project (CHIP) of Marion/Polk counties says, "CHIP believes that, at a minimum, zip code level data provides the kind of local information needed by community leaders and policy makers to assess the health of their community and make plans to address areas of concern."⁶⁰ Collecting and reporting such data for all 36 counties would be expensive, but beginning with five or six of the most populous would start to meet a clear need.

The set of health benchmarks should be reexamined to enhance its internal logic and relevance.

Benchmark selection has consumed much of the Progress Board's attention throughout its relatively brief history. Between 1994 and 1997, the number of benchmarks was reduced from 272 to 92. The Board has made either major or minor revisions nearly every two years. In keeping with Oregon's participatory culture, the Board has opened the benchmark selection process to thousands of organizations and people over the last decade. Individual benchmarks reflect the wisdom of experts inside and outside of government.

However, because the benchmark process has involved a series of minor changes over time to the set of health indicators, they lack coherence. It is not simply a matter of why one benchmark and not another is included—although this is an important question—but of what the set is supposed to represent. As a group, what do these indicators tell us about the collective well-being of Oregonians? Are the dozen or so health-related benchmarks meant to represent some vision of Oregonians' ideal health? Does the Board want these indicators to define a healthy population, or are they actually discrete measures?

Important questions about individual benchmarks should be asked. What does the number of HIV cases tell us about Oregonians' health? How central is the reduction of AIDS—a goal that the vast majority of Oregonians would almost certainly endorse—to Oregonians' dream of the future? How does one justify including a benchmark for early HIV diagnosis when the AIDS death rate is 2.2 per 100,000 people, and excluding one for heart disease, with 232 deaths per 100,000? In short, why use these benchmarks? Oregon needs a coherent vision of its future health, to which the benchmarks would guide us.

The connections among health and other indicators should be better articulated.

Oregon's strategic plan assumes that the three goals of *Oregon Shines II*—"Quality Jobs," "Safe, Caring and Engaged Communities," and "Healthy Sustainable Surroundings"—are related to the benchmarks. The benchmark measure Oregon's progress toward its strategic vision. But the Board's descriptive or statistical analysis does not establish the relationships among various clusters of benchmarks. For example, an obvious relationship exists between good health and a child's readiness to learn, or between teen pregnancy and securing a desirable job, yet no significant effort is made to explain the relationships between individual benchmarks or clusters of benchmarks.

The Board acknowledges these relationships in something it calls the "Circle of Prosperity," which "is based on the assumption that the social and economic well-being of Oregonians depends on the interconnectedness of quality jobs, a sustainable environment, and caring communities." This is not a specific or useful guide to making policy or even to understanding the relationships among benchmarks. This is particularly important given the comprehensiveness of *Oregon Shines* and the benchmark process. What is required to uncover the relationships is substantial, sophisticated data analysis that is currently beyond the capacity of the Progress Board. Experts at other state agencies or private researchers could be enlisted to provide the skills for such analysis.[61](#)

Community ownership of the Oregon Shines vision and the benchmarks should be reinforced.

From their inception, *Oregon Shines* and the benchmarks were portrayed as a project of Oregonians, not merely of their government. As the examples of Deschutes, Jackson and Josephine, Marion, and Tillamook counties indicate, communities are deeply involved in local benchmark projects. Perhaps understandably, the situation is different at the state level. Although the health benchmarks are intended to evoke a community-wide effort, in practice and in media coverage that vision tends to shrink to a focus on state government only.

This narrowed focus is encouraged and perpetuated by the *1999 Benchmark Blue Book: Linking Oregon Benchmarks and State Government Programs*. The OPB deliberately linked specific benchmarks to specific state agencies in response to community leaders' criticism during the development of *Oregon Shines II*. Their message was: "Get your own house in order, state government, before you come around telling us—nonprofits, the private sector, and local governments—that we must do more." Nevertheless, the Board pays little attention to links between benchmarks and nongovernmental organizations like the Oregon Medical Association, private hospitals, or the United Way. Media coverage tends to reinforce the idea of government ownership and responsibility for the benchmarks.

One final factor contributes to the popular misconception that the benchmarks measure government, rather than total community, performance. In its reports since 1997, the Progress Board has assigned a letter grade to each benchmark based upon the progress made toward the target. For example, the 2001 report gave Oregon a D+ for prenatal care, a D- for early HIV diagnosis, and an A for reduced premature mortality.[62](#)

The widely held view is that good or bad performance on health indicators is the responsibility of public officials, not something influenced by the general public, by socioeconomic factors like economic recession, and by a large transient population. Perhaps this is because "Oregon" in the abstract cannot be held accountable for results, or because the press has difficulty explaining that the community owns the benchmarks, or because benchmark grades are one of the few tools that legislators have for holding government agencies accountable. Whatever the reason, the private and nonprofit sectors, with a few notable exceptions, have yet to shoulder their fair share of responsibility for reaching the targets in the Oregon benchmarks.

CONCLUSION

For those familiar with performance-based management systems in the private sector, in which the work of individuals and organizations is evaluated on the basis of how well it meets targets, the Oregon benchmark

program will be a disappointment. Similarly, those interested in following Oregon's lead will question the value of a program that has shown little broad-based, sustained progress toward improving the health of Oregonians. The data in table 1 and the three case studies reported here provide meager support for the benchmark system. Nevertheless, we think that much of Oregon's experiment is worth praising and emulating.

We set out to answer two questions. First we asked, "Are Oregonians healthier than they would otherwise be as a result of the Oregon benchmarks?" Our conclusion is "probably not, although we cannot be certain." During the past decade, Oregon has done better than the national average on some health outcomes but worse on others. In a few areas that should be hallmarks of a strategic vision like *Oregon Shines*—like early prenatal care, reduced child abuse and neglect, and reduced alcohol use among eighth-graders—Oregon's performance is lagging. We believe, however, that systemic changes that are slowly taking shape should eventually lead to better health for Oregonians.

Second we asked, "Is the public health community better off because of the Oregon benchmarks?" Our conclusion is "yes." The increased visibility that the benchmarks have brought to public health issues is universally recognized as beneficial. Even the controversial grades assigned by the Progress Board have drawn attention to issues that might otherwise have been overlooked.

The Oregon benchmark experiment remains just that—a much-scrutinized work in progress. Over the years, *Oregon Shines* and the benchmarks have played many roles. First, they were a powerful vision for a better future created by a charismatic governor who wanted to inspire Oregonians to bigger and better things. Then they became a new tool that allowed different levels of government to exchange stringent rules and regulations for better results. Along the way, they were considered "magnets for collaboration" that prompted disparate interests to coalesce around a common vision. They have always lurked in the background, with their unfulfilled potential for helping state agencies and their partners become more accountable for achieving high-level outcomes. Even as this report is drafted, the Progress Board has entered its next stage of evolution—moving to the state Department of Administrative Services so it can provide better links between state agency activities and the benchmarks.

In the end a question remains: Would other states be well advised to adopt a benchmark process based upon the Oregon model? We believe they would. Aside from the various advantages discussed in this report, *Oregon Shines* and the benchmarks offer Oregonians a stable vision for the future that all of us can use to set goals, develop plans, or see how our communities are doing. To our knowledge, no other state in the country has had more success at this than Oregon.

APPENDIXES

APPENDIX A. BENCHMARK PROGRAMS IN SIX OTHER STATES

Connecticut⁶³

The Connecticut Progress Council was created in 1993 in recognition of "the need for government, like business, not only to plan long range, but to see that those plans are implemented." The 28-member council was required by statute to submit biennial benchmark reports to the Connecticut General Assembly for use in developing the state budget. In January 1995 the Progress Council issued its first—and last—report, *Goals and Benchmarks for the Year 2000 and Beyond*. The report contained 300 benchmarks organized into five categories: families and communities, education, health, the economy, and the environment. Each section contained a set of goals, such as "All Connecticut residents will enjoy complete physical, mental, and social well-being."

The goals were followed by a series of measures that tracked trends in Connecticut since 1990 and indicated what progress state leaders wanted to make in five-year increments, between 2000 and 2015. For example, black infant mortality had been 17.8 per 1,000 live births in 1990; the goal was to reduce it to 9 per 1,000 by 2005. The overall vision and specific goals and indicators were chosen by the Progress Council, based upon comments from Connecticut residents at a series of forums and regional meetings.

Shortly after issuing its report, the Progress Council was disbanded because it had little time to become firmly established before the gubernatorial transfer from Lowell Weicker (I) to John Rowland (R). The new governor was uninterested in continuing the Council.

Florida⁶⁴

In 1992 Governor Lawton Chiles appointed the Commission on Government Accountability to the People (the GAP Commission), which received statutory status in the 1994 Government Performance and Accountability Act. The Commission set out to provide "the kind of information that will help people make decisions about how much or how little government they want." By focusing on the results of government activity the Commission hoped to answer a basic question: "How are we doing, Florida?"

Over a period of three years the Commission looked at similar efforts, including Oregon's benchmarks and Minnesota's milestones, as well as at the views of the general public, officials in state agencies, and leaders of business and civic organizations. Ultimately the Commission chose seven areas to monitor: safety, learning, health, economy, environment, government, and families and communities. A group of experts from the public and private sectors reviewed hundreds of indicators for these areas and proposed 270. The health category had a subcategory, "beginning life healthy," with indicators for births to teenagers, low birthweight babies, infant mortality, AIDS- and drug-afflicted babies, and medical screening of infants.

The Commission issued its first report, *The Florida Benchmarking Report*, in February 1996, calling it a "work in progress." A number of indicators had no data, and the Commission decided not to establish future goals at the time. Instead it identified nearly 100 organizations with "broad state interests" and knowledge about specific issues related to specific indicators. This in turn led the Commission to identify about 2,000 Floridians who were subsequently asked what they thought were "ambitious, yet realistic" targets for 2000 and 2010 in their own areas of expertise. More than 700 people responded. Based upon their recommendations, the GAP Commission issued its second report in June 1997, *The Critical Benchmarks and Goals Report*. It covered 57 benchmarks representing those issues "most important to the quality of life" in the state. The report provided historical data on each indicator, comparisons with the national average, and targets for 2000 and 2010.

The following year the Commission issued the second edition of *The Florida Benchmarking Report*. It covered all 270 indicators, although targets were again limited to the 57 critical indicators. In addition, a grading system was added that marked progress in reaching the 2000 target for the critical indicators. The Commission is now defunct because of a conflict between (former) Governor Lawton Chiles and the Commission chairperson.

Maine⁶⁵

The Maine Economic Growth Council was created in 1993. Its task is to set forth "a vision and goals for the state's long-term economic growth" by consulting with people in government, education, business, and labor. The Council, which consists of 19 members drawn from government and the private sector, has issued seven annual reports since 1993. The most recent is *Measures of Growth, 2001: Performance Measures and Benchmarks to Achieve Sustainable Long-Term Economic Growth for Maine*.

This latest report envisages "a high quality of life for Maine citizens." Central to that vision "is a sustainable economy that offers an opportunity for everyone to have rewarding employment and for businesses to prosper." As in Oregon, economic prosperity is seen as contingent upon the overall well-being of Maine citizens. Each report identifies 58 indicators in six broad areas and benchmarks for each. The six areas are: innovative business, skilled and educated workers, vital communities, efficient government, state-of-the-art infrastructure, and healthy natural resources. For example, the vital communities area includes low birthweight infants, cigarette smoking, and overweight adults. Where data are available, the report compares Maine's progress, or lack of it, during the last decade or so with that of northern New England and the entire United States.

The annual report is intended for use by state legislators, the business community, and the people of Maine, who "may look to the benchmarks as a way to evaluate how we are doing as a whole at improving the economy and moving toward" the state's long-term vision. To strengthen citizens' and organizations' involvement with the project, the Council has created an "Adopt-A-Benchmark" program, which encourages groups to choose a benchmark and help foster progress toward meeting that benchmark's goals.

Minnesota⁶⁶

In 1991 more than 10,000 Minnesotans participated in public hearings around the state to share their views on Minnesota's future. Citizens were later asked to review the draft of a document that grew out of these meetings, *Minnesota Milestones: A Report Card for the Future*. The project was initiated by Governor Arne H. Carlson and based on the conviction "that defining a shared vision, setting goals, and measuring results will lead to a better future for Minnesota's people." The project was very much in keeping with the movement to reinvent government in the early 1990s. The final report proclaimed "a new way of thinking about government" and "a new way to hold public officials accountable." The report contained 20 broad goals, like a reduced percentage of low birthweight babies and an increased percentage of children who are adequately immunized. As in Oregon, it included recent

data on each milestone, as of 1990, and targets through 2020.

Unlike Oregon, Maine, and North Carolina, Minnesota has no separate agency or board responsible solely for the milestones. A cabinet-level executive agency called Minnesota Planning collects and analyzes indicator data and issues reports. Since the first one in 1992, the planning agency has issued progress reports for 1993, 1996, and 1998. The latest report, *Minnesota Milestones: Measures That Matter*, issued in 1998, followed the format of the original report with 19 goals and 70 milestones. *Minnesota Milestones* describes the state's progress on each milestone. Where available, it provides either state targets for the future or comparisons with the national average on the particular measure. The next progress report will be released in 2002.

North Carolina⁶⁷

Beginning in 1971, North Carolina made long-term plans through a series of one-time or short-term projects and reports. Then the 70-member bipartisan Commission for a Competitive North Carolina (1993–1995) was asked by Governor James B. Hunt, Jr., to develop a long-term vision for the state. That vision was presented in a 1995 report, *Measuring Up to the Challenge: A Prosperous North Carolina in a Competitive World*. It identified eight areas that the state would have to focus on to ensure sustained economic vitality: healthy children and families, quality education for all, a high-performance workforce, a prosperous economy, a sustainable environment, technology and infrastructure development, safe and vibrant communities, and active citizenship/accountable government.

The report specifically drew upon the Oregon Progress Board and its benchmarks to illustrate the direction it would take and the methods it would use. The report concluded: "If the work of the Commission for a Competitive North Carolina is to be more than a document that lines the shelves of government offices, there must be an ongoing mechanism to continue and guide the process." The Commission decided that "the best solution is to create a North Carolina Progress Board [NCPB], similar to the model developed in Oregon."

In 1995 the NCPB was created as a temporary body with 11 members. Two years later, the NCPB published a report, *Measuring Our Progress*, which examined four of the eight areas in the previous report.

In 1999 a new, permanent Progress Board was established, with 21 members, administratively part of the University of North Carolina Board of Governors and physically located on the Centennial Campus of North Carolina State University. The governor is an ex officio member of the Board and its chair. The governor appoints eight members; the speaker of the house, the president pro tempore of the senate, and the Board itself appoint four members each.

In June 2001 the Progress Board released a report, *NC 2020*, about the eight areas originally identified in 1995. *NC 2020* describes progress toward the goals in each area. Under the category of healthy children and families, the Progress Board set the general goal that "North Carolinians will follow good health practices." Specific indicators under this goal included reductions in smoking, obesity, sexually transmitted diseases, and substance abuse.

Vermont⁶⁸

Since 1992 the Vermont Agency of Human Services has issued an annual report, *The Social Well-Being of Vermonters*, to describe "governing by results." Unlike Oregon and the other states surveyed here, Vermont does not have a comprehensive plan based directly on economics. It measures "economic security" in personal terms—like adult literacy and average annual wage—rather than by things like economic diversity or the state's record in attracting new businesses. Instead Vermont emphasizes social indicators relating to families, pregnant women, infants, children and youth, and the elderly. The Vermont program differs from the Oregon model, too, because it does not involve citizens in shaping a vision and choosing appropriate measures of progress toward it. Nevertheless, Vermont's report on social well-being is an alternative system for tracking outcomes.

The latest report, *The Social Well-Being of Vermonters, 2001: A Report on Outcomes for Vermont's Citizens*, identifies nine general goals—like "pregnant women and young children thrive"—and more than 60 indicators—such as "new baby" visits, childhood immunizations, and reduced poverty for young children. The report tracks Vermont's progress since the 1980s on each indicator for which time-series data are available and compares it with the nation as a whole. There is also a 2010 target for each measure.

Vermont, like Oregon, monitors these indicators at the community level. Since 1996 the Vermont Agency of Human Services, in collaboration with the state's Department of Education, has issued yearly Community Profiles that include 60 indicators of individual, family, and community well-being. The profiles use the same nine goals as *The Social Well-Being of Vermonters* but generally have more indicators per category. Although many indicators come from the statewide list, many others do not. In the profiles, "community" means a "school supervisory union," which typically consists of several adjacent towns and perhaps a city. For each supervisory union, seven

to ten years of data are presented. The communities' latest data are compared with their previous data, with the county in which they are located, and with the state average for each indicator. For some indicators, the community's progress is compared to the statewide goals in *Healthy Vermonters 2000*.

APPENDIX B. OREGON PROGRESS BOARD PUBLICATIONS

Mar. 2001	<i>Achieving the Oregon Shines Vision: The 2001 Benchmark Performance Report*</i>
Mar. 2001	<i>Achieving the Oregon Shines Vision: The 2001 Benchmark Performance Report-Highlights*</i>
Feb. 2001	<i>A Brief History of the Oregon Progress Board*</i>
Sept. 2000	<i>Oregon State of the Environment Report 2000-Full Report*</i>
Sept. 2000	<i>Oregon State of the Environment Report 2000-Statewide Summary*</i>
Sept. 2000	<i>Oregon Progress Board At-a-Glance*</i>
Nov. 1999	<i>Oregon Benchmarks County Data Book*</i>
May 1999	<i>Benchmark Blue Book: Linking Oregon Benchmarks and State Government Programs*</i>
Mar. 1999	<i>Achieving the Oregon Shines Vision: The 1999 Benchmarks Performance Report*</i>
Mar. 1999	<i>Achieving the Oregon Shines Vision: The 1999 Benchmarks Performance Report-Highlights*</i>
May 1998	<i>Oregon Benchmarks County Data Book*</i>
Jan. 1997	<i>Oregon Shines II: Updating Oregon's Strategic Plan*</i>
Jan. 1997	<i>Oregon Shines II: Updating Oregon's Strategic Plan-Highlights*</i>
Mar. 1996	<i>Governing for Results: Using Benchmarks to Define and Measure Progress Toward Strategic Priorities+</i>
Jan. 1996	<i>Data Directory, Oregon Benchmarks+</i>
Mar. 1995	<i>An Investment Opportunity: Redesigning Oregon's Public Assistance System to Reduce Poverty by Placing More Oregonians in Jobs+</i>
Dec. 1994	<i>Oregon Benchmarks: Standards for Measuring Statewide Progress and Institutional Performance+</i>
June 1993	<i>Catalytic Leadership Handbook*</i>
May 1993	<i>Oregon Values and Beliefs-Summary*</i>
Dec. 1992	<i>Oregon Benchmarks: Standards for Measuring Statewide Progress and Government Performance#</i>
Nov. 1991	<i>Human Investment Partnership: Achieving Benchmarks for Exceptional People+</i>
May 1991	<i>The Oregon Literacy Survey+</i>
Jan. 1991	<i>Oregon Benchmarks: Setting Measurable Standards for Progress#</i>

Oct. 1990	<i>Oregon Benchmarks: Setting Measurable Standards for Progress</i> Workbook Summit on Exceptional People#
May 1990	<i>Oregon Benchmarks: Setting Measurable Standards for Progress</i> -Public Review Draft#
May 1989	<i>Oregon Shines: An Economic Strategy for the Pacific Century</i> *

* Available on the Oregon Progress Board Web site at <http://www.econ.state.or.us/opb>

+ Available by writing to the Oregon Progress Board, 775 Summer Street, NE, Salem, OR 97310

Out of print

NOTES

¹Oregon Progress Board 1991, 1–4.

²It would be an interesting exercise, although beyond the scope of this report, to compare Oregon's benchmark target progress with that of the United States on nonhealth measures. Might one expect Oregon to perform better than the rest of the nation on health (or protecting the environment) than, say, economic development?

³Personal communication with Glenn Young, executive director, Vancouver British Columbia Board of Trade, May 12, 2000.

⁴Personal communication with Richard Reiten, president and CEO, Northwest Natural, March 20, 2002.

⁵Telephone interview with Jerry Street, administrator, Jefferson County Health Department, November 17, 2000.

⁶Telephone interview with Susan Irwin, director, Washington County Department of Health and Human Services, January 8, 2001.

⁷Peirce 1994.

⁸See Barrett and Greene 1999, 73; Lewis and Dunkle 1996.

⁹See also Nelson 1995, 9.

¹⁰Oregon Progress Board 1991a.

¹¹Varley 1999, 7.

¹²Personal communication with Mark Gibson, health, human services, and labor advisor to Governor Kitzhaber, April 1, 2002.

¹³Governor Barbara Roberts quoted in Varley 1999, 11.

¹⁴Quoted in *ibid.*, 12.

¹⁵For a more complete discussion of Republican and Democratic criticisms, see Varley 1999, 17–9.

¹⁶Oregon Department of Administrative Services n.d.

¹⁷Interview with Grant Higginson, state health officer and deputy administrator, Oregon Health Division, Portland, August 4, 2000. Hereafter, Higginson interview.

¹⁸The Guidelines and related training materials are available on the Progress Board's Web site at <http://www.econ.state.or.us/opb>.

¹⁹Interview with Jennifer Woodward, State Health Division, Portland, August 4, 2000.

²⁰Interview with Hersh Crawford, director, Office of Medical Assistance Programs, Salem, July 18, 2000.

²¹Oregon Commission on Children and Families n.d., 4–5.

²²67th Oregon Legislative Assembly—1993 Regular Session, House Bill 2004, July 27, 1993.

²³Telephone interview with Carin Niebuhr, director, Jackson County Commission on Children and Families, November 3, 2000.

²⁴Higginson interview.

²⁵Interview with Jeff Davis, administrator, Marion County Health Department, August 10, 2000.

²⁶Interview with Jim Lussier, president, St. Charles Hospital, Bend, August 11, 2000.

²⁷Rogue Valley Civic League 1997.

²⁸Rogue Valley Civic League n.d.

²⁹Interview with Sue Densmore, Communications Strategies, Medford, August 18, 2000.

³⁰For a copy of the MOU and a complete list of the signatories, see Macy n.d., Appendix B.

³¹Schorr 1997, 19.

³²Connie Revel quoted in Landauer 1996.

³³Lewis and Dunkle 1996, 39.

³⁴Dyer 1996.

³⁵Sue Cameron quoted in Gore 1996, 56.

³⁶Dyer 1996, 16.

³⁷Interview with Governor John Kitzhaber, Salem, April 17, 2002.

³⁸Interview with Olivia Clark, director of legislative and intergovernmental relations, Office of the Governor, Salem, February 1, 2001.

³⁹John Kitzhaber, "Oregon Option Celebration Remarks," March 15, 1999.

⁴⁰Governor's Mental Health Alignment Work Group 2001, 2.

⁴¹*Ibid.*, 27.

⁴²Electronic communication from Pam Curtis, health, human services, and labor policy analyst, December 7, 2001.

⁴³Oregon Progress Board 2001, 42.

⁴⁴The Tillamook teen pregnancy story has been well told in a study by Luke and Neville n.d. The study was made available to the authors by Sue Cameron.

⁴⁵*Ibid.*, 9.

⁴⁶Quoted in *ibid.*, 15.

⁴⁷*Ibid.*, 29.

⁴⁸*Ibid.*, 28.

⁴⁹Interview with Sue Cameron, former administrator, Tillamook County Health Department, Tillamook, July 26, 2000.

⁵⁰It is one of the great ironies of this story that in 2000, without any special effort or programs, Tillamook had a teen pregnancy rate of 7.8 per 1,000, a sharp drop from the rate of 21.0 the year before.

⁵¹U.S. General Accounting Office 1994, 1.

⁵²*Ibid.*

⁵³The bible of the reinvention movement is Osborne and Gaebler 1992.

⁵⁴For a recent survey of both statewide and agency-specific strategic planning programs in the United States, see Council of State Governments 1997.

⁵⁵Melkers and Willoughby n.d.

⁵⁶See, for example, Gore 1995, 1996.

⁵⁷In recent years, representatives from Australia, Brazil, Canada, China, Denmark, Ethiopia, Japan, Mexico, New Zealand, Norway, and Scotland have closely studied the Oregon approach. Similar projects are underway in Australia, Mexico, and Scotland.

⁵⁸Oregon Progress Board 1990, 1.

⁵⁹Barrett, Greene, and Mariani 2001, 89.

⁶⁰Community Health Information Project n.d., 1.

⁶¹See, for example, Kissler and Fore n.d.

⁶²For an explanation of the Progress Board's grading system, see "Grade Calculations" in Oregon Progress Board 2001, Appendix B, 89–97.

⁶³Material in this section has been drawn from Connecticut Progress Council 1995.

⁶⁴Material for this section has been drawn from Florida Commission on Government Accountability to the People 1996, 1997, 1998.

⁶⁵Material for this section has been drawn from Maine Economic Foundation 2001.

⁶⁶Material for this section has been drawn from Minnesota Planning 1992, 1998.

⁶⁷Material for this section has been drawn from Commission for a Competitive North Carolina 1995 and North Carolina Progress Board 2001.

⁶⁸Material for this section has been drawn from Vermont Agency of Human Services 2001a, 2001b.

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